

## The Future Role of Private Health Insurance

*The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.*

This policy brief deals with considerations of the role of private health insurance (PHI) alongside a public health system or public health insurance system. This has critical relevance to the future role of medical schemes under a National Health Insurance system in South Africa. The debate on this design issue is in its early stages and this material is designed to assist stakeholders and policy-makers as they grapple with the issues.

### 1. ANC Policy Proposals on PHI under NHI

The February 2009 draft NHI proposal from the African National Congress (ANC) task team<sup>1</sup> consisted of some 200 pages in which the phrase “medical scheme” cannot be found. Comments from that time suggested that private health insurance, that is medical schemes, could be closed down completely.

The June 2009 NHI proposal from the ANC task team<sup>2</sup>, reduced to some 64 pages, deals with medical schemes extensively and their perceived role in the problems in healthcare financing in South Africa. This proposal envisages that medical schemes will continue but on a voluntary basis, as at present. It is proposed that members will pay for NHI AND for any medical scheme they join. “While the NHI calls for mandatory membership for all South Africans through mandatory contributions and social solidarity, it is up to the general public to continue with voluntary medical schemes cover after they have contributed to the NHI Fund.”

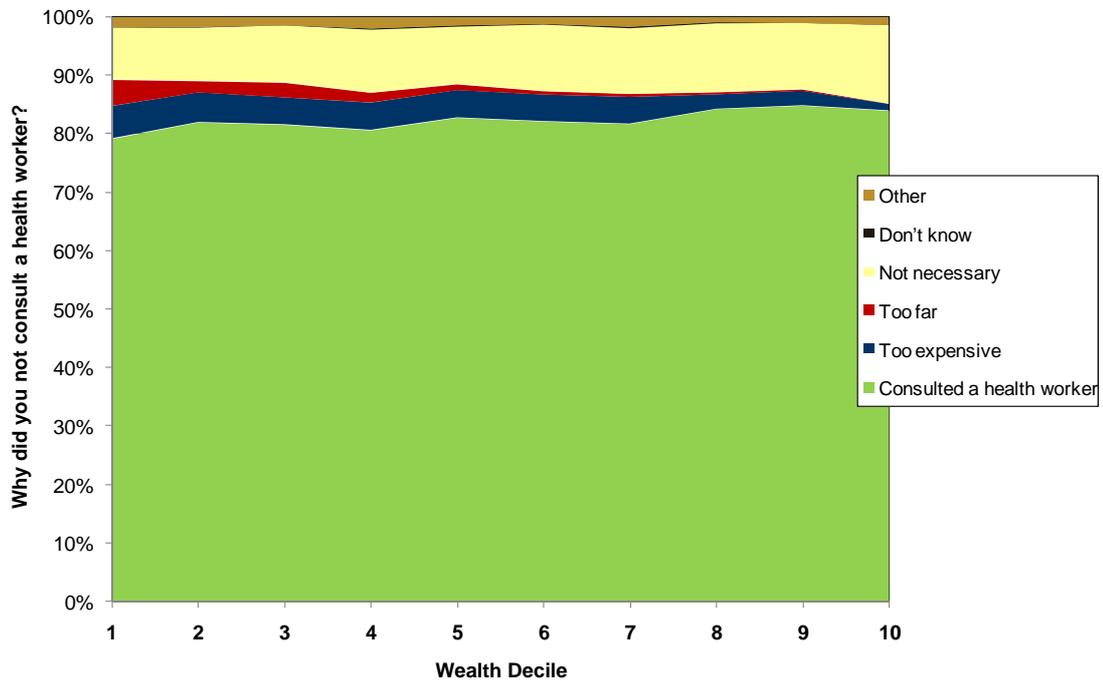
The contribution to NHI is envisaged to be through general taxes and “will be supplemented by a mandatory, payroll-related contribution. This mandatory contribution will be progressively structured and it will be collected by the South African Revenue Services (SARS). Everyone earning above the income tax threshold (adjusted annually) would be required to make this contribution (i.e. no one may ‘opt-out’ of the NHI), which will be shared between employers and employees.” The amount of this mandatory contribution had not been determined in the June 2009 report.

### 2. Universal Coverage

In a description of NHI in July 2009 the ANC said<sup>3</sup>: The National Health Insurance will: ... Expand health coverage to all South Africans [emphasis added]. This means there will be no financial barrier to access health care. All South Africans will be equally covered to access comprehensive and quality health care.”

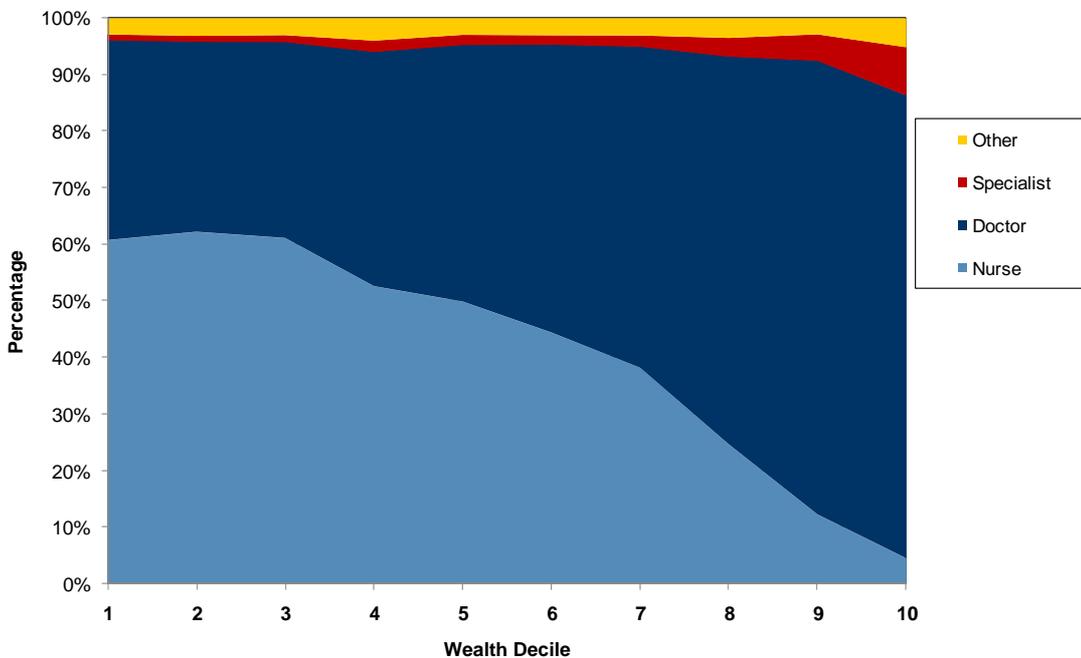
The June 2009 NHI proposal<sup>2</sup> says that “The goals of the national health insurance include... providing universal coverage for all South Africans, irrespective of whether they are employed or not”. “The introduction of a national health insurance system has been on the agenda of government since 1994. The key objective of such a system is to address the problems of the dual health system by promoting social solidarity in order to achieve universal coverage” [emphasis added].

The two graphs below from Prof Servaas van der Bergh show what is known about access to healthcare in South Africa by income group.



**Figure 1: Proportion of those ill that consulted a health worker and reasons why not.**

Source: Prof Servaas van der Berg, Stellenbosch University, using GHS2002-2007



**Figure 2: Health workers consulted by those who were ill.**

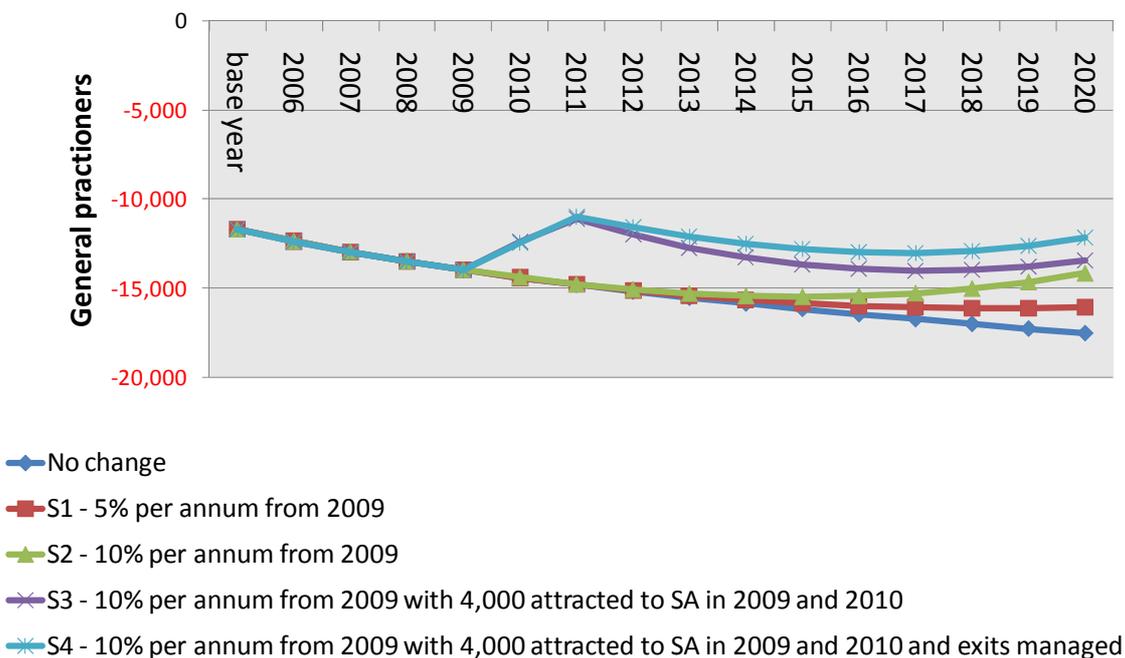
Source: Prof Servaas van der Berg, Stellenbosch University, using GHS2002-2007

It seems though that there is confusion in the debate between universal coverage for healthcare and universal coverage for health insurance. It is estimated that only some 16.4% of South Africans had health insurance cover in 2008<sup>4</sup>. However everyone in the country has access to healthcare, either in the public sector or through medical schemes, bargaining council funds or other employer-based arrangements.

Figure 1 shows that across all income groups about 80% of the population who needed care were able to access care. A further 9-14% decides they do not need to see a healthcare practitioner. Physical constraints (the distance that needs to be travelled), affect 5% of the lowest income group, reducing as income increases. Financial constraints affect only 6% of the lowest income group and this does not vary as much by income as might be expected.

The area of greatest difference is the type of healthcare practitioner consulted. The highest income group seldom see a nurse and have become used to going to a GP or directly to a specialist. Among the lower income groups, a nurse practitioner is the most common point of entry to the health system. Prof van der Berg makes the point that dissatisfaction with the current national health system is dissatisfaction with the quality of the care provided in the public sector. Demand projections indicate that satisfying public preferences would require double the current number of doctors' visits, as the public presently interprets quality care as access to private facilities and doctors<sup>5</sup>.

The debate around universal coverage thus needs to be recast: we do have universal coverage for healthcare. The question is whether it is feasible to equalise the quality of service as we do have differential access to GPs by income level. There is currently substantial research being conducted on the numbers of GPs and specialists practicing in the country and on the numbers needed by the health system. The graph below, from the Development Bank of South Africa (DBSA) Roadmap process<sup>6</sup> projects the shortage of GPs under various scenarios.



**Figure 3: Scenarios for dealing with the shortage of GPs**  
 Source: Alex van den Heever, DBSA Roadmap process, 2008

Note that the figures above are for the health service as it has been, with nurse-based clinics. The figures did not include the effect of the NHI promise that people would be able to choose a clinic or GP in their area<sup>2</sup>: "All South Africans can then choose which primary health care provider (which would generally include a number of different public sector clinics/community health centres and accredited multi-disciplinary practices) in the district they would like to register with and utilise health services."

### 3. Private Spend and Public Spend

The picture that is frequently used<sup>3,4,7</sup> to depict the inequity in public and private spend is one derived from work by Prof Di McIntyre of the Health Economics Unit at UCT. The average spend for various groups in 2005 was given as follows:

- R9,500 pbpa<sup>a</sup> for those belonging to medical schemes, which was 7.0 million in 2005 when the initial work was done but 7.9 million by end 2008<sup>8</sup>;
- R1,500 pbpa for the roughly 10 million people who use private primary care (on an out-of-pocket basis) and public hospitals; and
- R1,300 pbpa for the roughly 30 million people using public clinics and public hospitals.

Prof McIntyre issued a revised version of this with 2008 figures in a recent information sheet<sup>9</sup>:

- R11,300 pbpa for those belonging to medical schemes (this includes both medical scheme spending of R9,600 and estimated out-of-pocket payments of R1,700);
- R2,500 pbpa for the middle group (includes out-of-pocket payments to private primary care providers and government spending on hospital care); and
- R1,900 pbpa for those using government primary care and hospital services.

The impression is sometimes created by other commentators that all this spend is able to be pooled and then spent equally under NHI. This is much the same argument in transport as taking public expenditure on public transport, adding all the spend on private motor cars (of whatever luxury level) and private fuel usage, and then saying that all of this money should be available for an improved public transport system. A clearer distinction needs to be made between public money and private spend.

A distinction is also needed between spend on essential healthcare and true private purchases. For example, it is not fair to compare private over-the-counter out-of-pocket vitamin purchases to Government spend on anti-retroviral medication. When a healthcare purchase is fully private it competes with movie tickets and entertainment, not social expenditures. Another example is the spend on African Tradition Healers. Research has shown<sup>10</sup> that "The trade in traditional medicines in South Africa is estimated to be worth R2.9 billion per year, representing 5.6% of the National Health budget. With 27 million consumers, the trade is vibrant and widespread." This private expenditure does not appear to have been included in the figures above.

### 4. Public Subsidy of Private Insurance in South Africa

A very necessary comparison is the expenditure by Government on someone using public sector facilities compared to the subsidy given by Government for private health insurance. This is the so-called Tax Expenditure Subsidy (TES) which arises because of the tax break given to people who belong to medical schemes.

Tax expenditure subsidies can be considered to be a leakage of tax revenue. They are often put in place to incentivise a particular activity (for example, subsidies to farmers or to taxi-owners to scrap old vehicles) and then they persist under tax legislation. Because they are not part of the formal annual budget in parliament, they can persist for many years after their purpose has been fulfilled. Many OECD<sup>b</sup> countries include these tax subsidies in the budgeting process each year in order to allow parliament to reconsider whether they are necessary on a regular basis.

---

<sup>a</sup> pbpa means per beneficiary per annum, in other words per person per year, including adults and children.

<sup>b</sup> Organisation for Economic Co-operation and Development, see [www.oecd.org](http://www.oecd.org)

The TES for medical scheme membership and medical expenses in South Africa has been in place since well before 1994. The Melamet Commission in 1994 reported<sup>11</sup> that: “the tax deduction ‘encourages consumption of health care beyond the point where the costs of obtaining extra cover equate to the value of the marginal benefits received. Price signals are badly muffled. Medical cost inflation is thus encouraged.’ (Melamet Commission, 1994, p.44)”.

A report from the Centre for Health Policy, lead by Dr Max Price in 1995, was also strongly negative<sup>11</sup>, saying: ‘The subsidisation of this sector by the government is not consistent with the principles of health care funding by the state.’ The calculations showed the cost of the TES to be between R4 billion and R6 billion. The NHI Committee in 1995 also identified serious problems with the existing tax regime.

Writing in 2002, the Department of Health submission to the Taylor Committee<sup>11</sup> included a revised estimate of the TES of R7.8 billion. The Ministerial Task Team on Social Health Insurance reported in 2005<sup>12</sup> that the TES was estimated in 2005 to be R10,1 billion, which in that year was equal to some 20% of the public health budget<sup>2</sup>. At that stage the TES amounted to about R120 pbpm for medical scheme members (and very unequally distributed), while the public sector spend was R96 pbpm.

McIntyre and Van den Heever<sup>7</sup>, commenting on the similarities in proposals for mandatory insurance over the years, wrote: “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 [this was in 2006], 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.” The graph below illustrates the effect of the tax expenditure subsidy and the per capita (per head) subsidy on individuals in 2007 terms<sup>13</sup>.

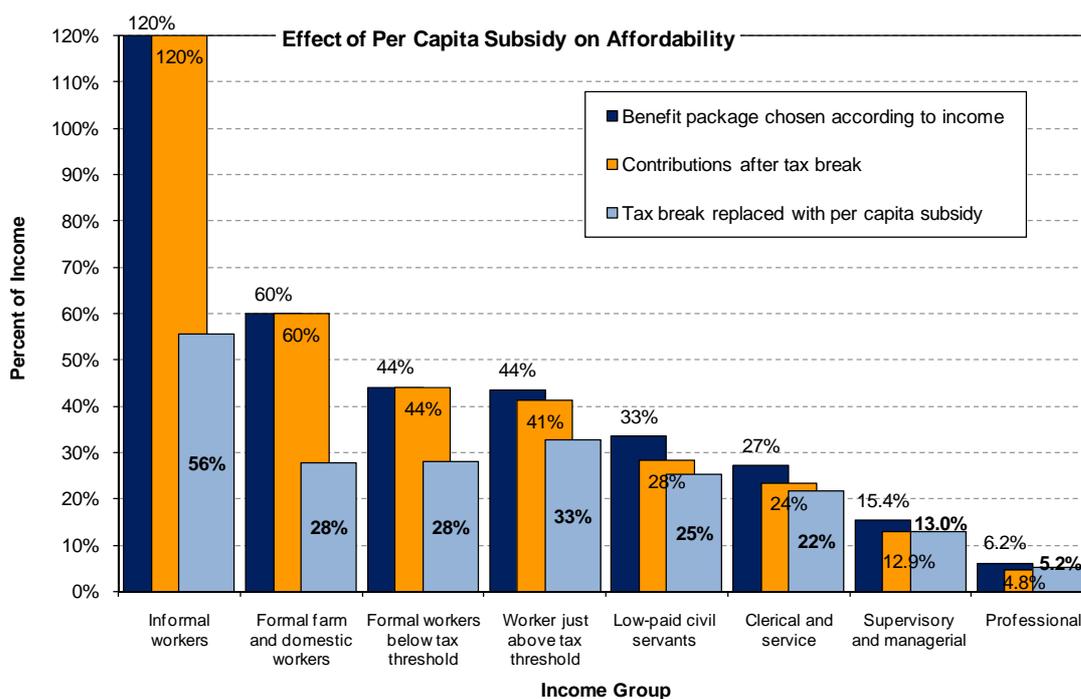


Figure 4: Effect of Existing Tax Subsidy compared to Effect of Per Capita Subsidy<sup>13</sup>

The graph illustrates the core problem with a tax subsidy, no matter how it is structured: if you are not paying income tax, then there is no subsidy. This means that individuals below the tax threshold<sup>c</sup> get no subsidy while those just above the tax threshold get a small subsidy so that the price of the typical medical scheme falls from 44% of income to 41% of income. At the highest income group, the tax subsidy reduces the cost of a comprehensive package from 6.2% of income to only 4.8% of income.

Despite some important reforms in 2006 to ensure that the self-employed and those who had healthcare provided by the employer received equal treatment, the fact remains that lower income groups cannot afford the same size medical scheme packages as the most wealthy and thus the subsidy they get from Government is smaller.

A further concern with the tax subsidy is that retired people, whose incomes tend to fall in retirement and whose health needs increase, are less likely to get a subsidy for medical scheme membership. The tax threshold also has escalated each year, meaning that if wages do not keep pace with the tax threshold increase, that people get a reduced subsidy.

McIntyre, McLeod and Thiede, writing on the 2006 reforms<sup>14</sup>, argued that "The only way to provide an equitable subsidy to lower income workers is in the form of a direct subsidy to the medical scheme on their behalf. The proposals from the Department of Health for a per capita subsidy to be payable to all would substantially improve affordability of healthcare for lower income workers. This would also be neutral to the fiscus in future."

The tax break is contrasted in Figure 4 with the proposal of a per capita subsidy. It is shown in the graph that the cost of the typical medical scheme package for those earning below the tax threshold would fall from 44% of income to 28% of income. This is still a very large amount but begins to come within the bounds of possible sharing of costs between workers and employees. The effect on those just above the tax threshold is to reduce costs from 41% of income to 33% while the highest income group pays slightly more, up from 4.8% of income to 5.2%. While this does not provide a complete solution to the need for income cross-subsidies, this simple change would make a very large difference in the affordability of medical schemes for lower income workers.

The June 2009 NHI proposal from the ANC task team<sup>2</sup> commented as follows on this subsidy: "This tax policy has major flaws. Firstly it is inconsistent with the principles of access, efficiencies and equity. The current tax expenditure subsidy on medical schemes' deduction has not contributed to increased access by low income earners in medical scheme membership nor improved the rising costs of the industry. Those in the high income tax brackets continue to benefit more from the subsidy than the middle and low income groups. Furthermore, the workers, including the informal workers, not covered by medical schemes, do not benefit from the tax subsidy at all. Secondly, even when low income earners get tax subsidy, they would not be able to afford adequate coverage, leaving them with modest benefits and high cost sharing that will often make health care unaffordable."

"Additional funding for the NHI system will include the elimination of the current tax-deductions for medical scheme contributions and channelling these funds to the NHI Fund to provide additional funds into the NHI system".

Despite 15 years of commissions and reports all arguing for the abolition of the tax break for medical scheme membership, this incentive to join the private sector has been left in place each year. It is incomprehensible to many researchers that this adverse incentive should be allowed to continue. The proposal for a per capita subsidy would mean that every citizen would receive the same amount of subsidy for healthcare: in 2008 this would have been R1,900 pbpa which is the amount spent on those using government primary care and hospital services.

---

<sup>c</sup> The tax threshold is the level at which people begin to pay income tax. This is at R54,200 per annum or R4,517 per month for those under age 65 in the tax year 2009/10. For those older than 65, the tax threshold is higher at R84,200 per annum or R7,017 per month.

## 5. Single Tier vs. Multi-Tier Systems

McIntyre and Van den Heever wrote<sup>7</sup> on the areas of major debate that still existed in 2007 with regard to National Health Insurance, identifying the issue of a single tier vs. a multi-tier system<sup>d</sup>. “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). ... 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. ...”

“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. ... 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. 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).”

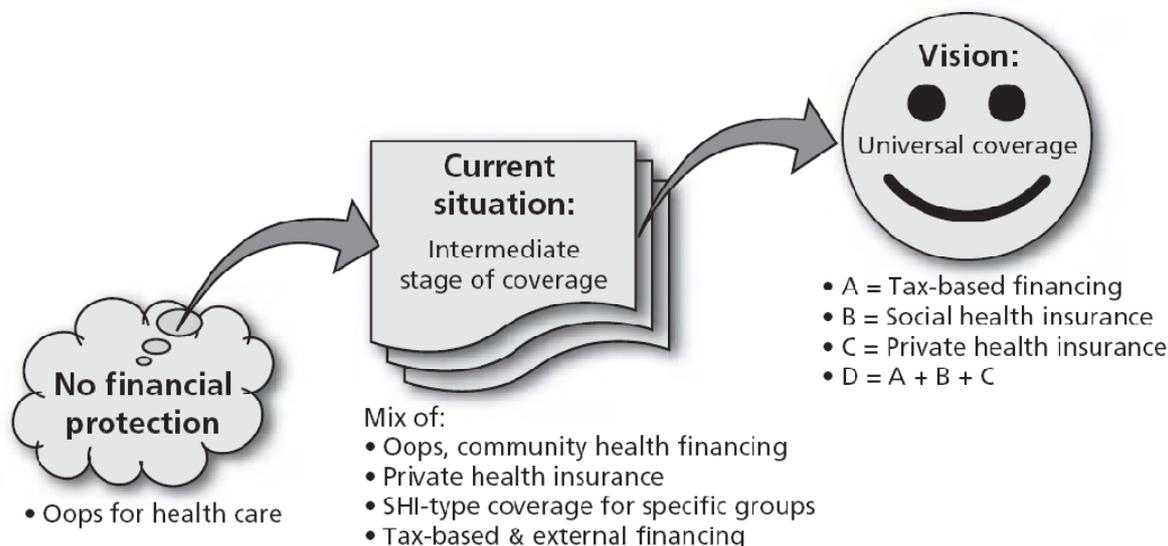
“This strongly suggests that it is simply not feasible to eliminate ‘all’ health services differentials in South Africa ‘in the short-term’. Nevertheless, a NHI is feasible in the foreseeable future, with a comprehensive BBP and substantially improved public services as the core of service provision. 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”.

The core issue in the NHI debate will be what is considered to be equitable. While it is necessary to be careful not to conflate multi-tier systems and multiple purchasers, the arguments from Hussey and Anderson<sup>15</sup> on social solidarity are also relevant to the debate on tiering. “A single-payer insurance system can ... foster citizens’ trust in the ability of the government to protect their welfare, enhancing the population’s view of the legitimacy of the government. However, in some cases multiple insurance pools might improve the political support of the government. For example, better-off individuals who feel that they are contributing more than their fair share towards insuring the health risks of others may oppose the health insurance system. Allowing them to opt out of a single-payer insurance system may provide greater social solidarity in a normative sense, by securing the political support of high-income earners for the public insurance system. This is particularly important in low- and middle-income countries where the high-income individuals and large industries must be willing to pay most of the cost of the reforms.”

---

<sup>d</sup> Social security systems have components that are commonly grouped into three tiers, defined by the way individuals contribute to each tier and draw benefits from that tier. In a single tier system there is only one system for everyone; this is typically found in the industrialized developed countries. In developing countries it is common to find multi-tier systems. ; for example a public health system as Tier 1; a mandatory contributory fund or funds for those employed as Tier 2; and purely private insurance and out-of-pocket spend in Tier 3.

The diagram below illustrates the point that universal coverage does not necessarily mean a single tier system. Universal coverage can be achieved through a combination of funding methods (i.e. a multi-tiered system).



**Figure 5: Universal Coverage as a Combination of Different Tiers**

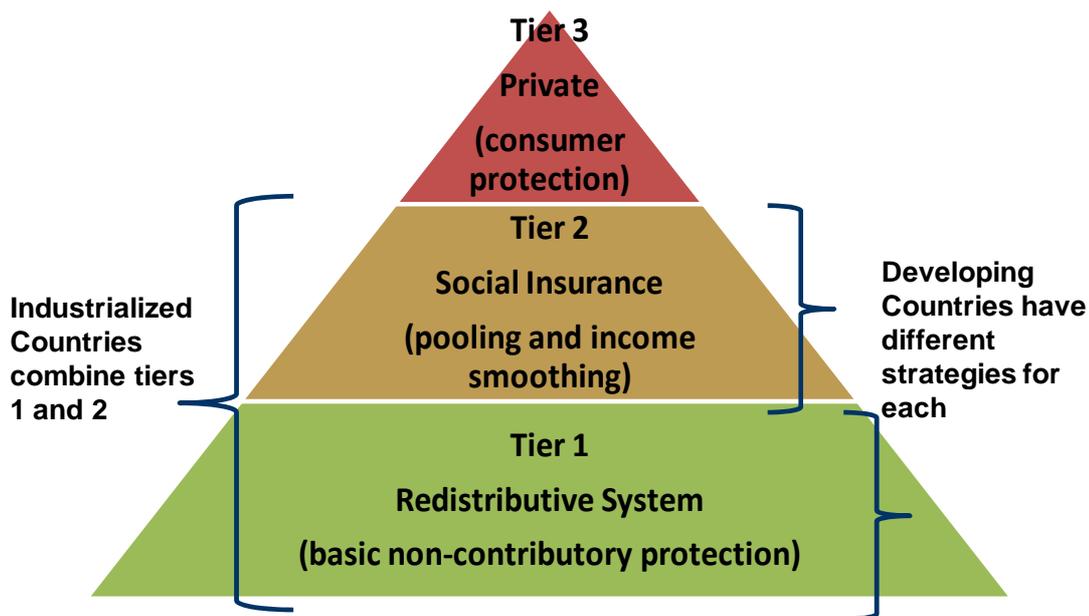
Source: Kirigia et al<sup>16</sup>, Health financing patterns and the way forward in the WHO African Region.

Kirigia and colleagues explain that “SHI has not taken root in the (African) Region. Its limited contribution to health financing could be attributed to wide spread poverty, and a high proportion of the population working in the informal sector.”

“However, due to inequities related to out-of-pocket payments and the need for sustainable funding for the health sector, the Fifty-eighth WHO World Health Assembly adopted a resolution entitled ‘Sustainable health financing, universal coverage and social health insurance’<sup>17</sup>. The resolution urges Member States, among others, to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic healthcare expenditure and impoverishment of individuals as a result of seeking care”.

Governments in Africa are urged to develop plans that “... should map-out the monitored transition from the current situation characterised by predominantly out-of-pocket payments to a visionary situation of universal protection against cost-of-illness”. This might include a combination of tax-based financing, mandatory social health insurance and private insurance in a multi-tier system. The fundamental issue from an equity perspective, as McIntyre and Van den Heever wrote<sup>7</sup>, “is that the wealthy should not be permitted to ‘opt out’ entirely”. Much careful work is needed to find an equitable solution that accommodates a multi-tier system.

In the figure below, a national public health service funded from general taxation might form Tier 1. All employed, including public sector workers, might contribute on a mandatory basis to Tier 2 where there would be significant income cross-subsidies. This could encompass medical schemes, bargaining council schemes and other forms of workplace-based healthcare. Tier 3 cover would be a private matter and could be provided (for example), by medical schemes or insurance companies or paid by individuals out-of-pocket.



**Figure 6: Generic Multi-Tier Social Security Systems**

Source: Van den Heever, September 2009

This idea is taken further in the figure below which uses four tiers rather than three to differentiate between levels of protection needed in the contributory element. In this version there is a split between the Tier 2 mandatory system and a further tier of private contributions. Tier 2 might cover minimum benefits while Tier 3 might be the balance of comprehensive cover usually found in medical schemes. Tier 4 then becomes the purely private layer.

Strategic Dimension	Tier 1	Tier 2	Tier 3	Tier 4
<b>Revenue</b>	General tax	Payroll tax Mandatory contributions	Private contributions	Private contributions OOP
<b>Pooling and resource allocation</b>	Income CS take priority with Risk CS secondary	Risk CS take priority with some Income CS to maximize inclusion	Risk CS only	Ordinary actuarial insurance principles apply
<b>Package</b>	Predominantly supply rationed	Predominantly demand rationed	Demand rationed and ability to pay	No rationing – ability to pay predominates
<b>Purchasing</b>	Conventional budget planning and allocation with residual private contracting	Social insurance funds, regulated approved funds	Regulated approved funds	Regulated unapproved funds, employers, and households
<b>Provision</b>	Predominantly public entities with residual contracted private entities	Private providers with residual contracting of public sector services	Private providers	Private providers

**Figure 7: Possible Multi-Tier Framework for Healthcare**

Source: Van den Heever, NHI Research Workshop, November 2009

## 6. Conceptual Framework for the Role of PHI

The OECD initiated the Health Project in 2001<sup>18</sup> “to address some of the key challenges policy makers face in improving the performance of their countries’ health systems.” The three-year initiative provided substantial comparative information on the role of private health insurance across the OECD. “Governments in several OECD countries have used or considered using private health insurance (PHI) as a policy lever to promote certain health system goals, such as reducing financing pressures on public health systems, promoting individual choice and improving efficiency.”

In almost all OECD countries, private health insurance covers<sup>18</sup> “ ‘small risks’, ancillary and supplementary services such as dental and optical services, choice of provider, upgraded hospital accommodation, and luxury services. Often, these services are not provided, or only partly reimbursed, by public coverage systems. Coverage of home care, alternative medicine, long-term care and pharmaceuticals vary in relation to the generosity and structure of public health insurance.” Thus in OECD countries the role of PHI is essentially a tier 4 issue. In South Africa, however, the current minimum package is only roughly half of expenditure on healthcare and PHI could be used for cover in tier 2 and 3.

The diagram below provides an overview of the role PHI can play in health systems.

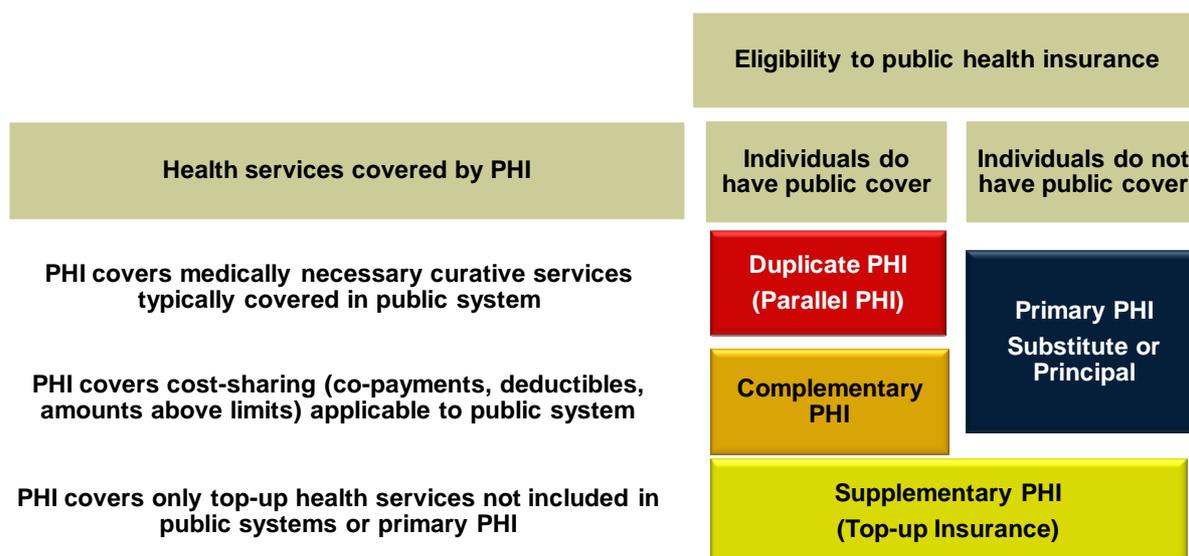


Figure 8: Possible Roles for Private Health Insurance<sup>18</sup>

Terminology used in the OECD is as follows:

- **Primary PHI**: the only available access to basic health cover where individuals do not have public health insurance.
- **Principal PHI**: where the social security scheme does not apply. Could be employer or union-based compulsory schemes.
- **Substitute PHI**: substitutes for public cover or employer cover.
- **Duplicate cover (Parallel PHI)**: cover already included under public insurance. Does not exempt individuals from contributing to public health insurance. Can offer access to different providers or levels of service.
- **Complementary cover**: covers all or part of the costs not otherwise reimbursed (e.g. co-payments).

- **Supplementary cover (Top-up Insurance):** cover for additional health services not covered by public scheme. May include services not covered by public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, or superior hotel and amenity hospital services.

The June 2009 NHI proposal is for medical schemes to be “duplicate PHI cover”. This will make medical schemes even more unaffordable than at present and the decline in membership could be very rapid. Initial and preliminary research suggests the numbers could decline from nearly 8 million lives to less than 1 million.

Another possible position is for medical schemes is to provide “substitute cover” where people may choose to belong to NHI or a medical scheme providing the equivalent to NHI as a minimum set of benefits. The medical scheme could also offer “supplementary cover” not otherwise included in the NHI package. The precise form that private health insurance is to take alongside a public health service still needs to be a matter of much research and debate amongst all stakeholders.

## 7. Public and Private as Technical Issues

The debates around public and private involvement in healthcare can be very heated when ideological positions are defended by all sides. But there is another way to think about these issues.

Prof Nicholas Barr argues<sup>19</sup> that “Depending on political perspective, markets were seen as ‘good’ or ‘bad’ – hardly a good guide to policy design. Recent developments in the economics of information, however, allow us to better evaluate when markets work well and when they do not. (The) article summarises the core of that theory and uses it to explain why Britain is right to have a national health service but not a national food service, and right to have free school education but to be introducing market forces into higher education.”

The interested reader is left to read the full paper, but essentially Barr argues that whether a service is provided by the public sector or the private sector is really a technical, not an ideological issue. “The key lesson is that ideology should come into the picture at the stage of setting the objectives of policy – how much redistribution should there be, how much weight should be given to promoting equal access to health care and education? But once the objectives are set the method should be chosen mainly on the technical grounds discussed (in the paper).”

“Markets are neither good nor bad; they are enormously useful in well-known and widely applicable circumstances, less useful in others. Where the necessary conditions fail, carefully designed intervention, for example through regulation, may improve matters. The real issue is the design of that intervention. For example, policy might be more effective in some areas if the state’s role changed from that of provision to that of regulating private providers. Policy is assisted by open and clear-minded discussion ...”

## 8. Conclusions, Some History and Implications

The February and June 2009 proposals on NHI from the ANC effectively relegate existing medical schemes to a “duplicate” role which would mean that those covered by medical schemes could fall well below 1 million people from the currently 8 million people covered. Debates around this issue tend to become politically and ideologically heated but there are strong economic arguments for looking at the public-private mix in technical terms and playing to the strengths of each sector.

It is often alluded to that National Health Insurance was first proposed in the ANC Health Plan of 1994<sup>20</sup> and that the resolutions made at Polokwane, which lead to the current proposals, are merely a continuation of that tradition. A careful re-reading of the ANC Health Plan of 1994 shows a different system being envisaged: the majority of that document is focussed on the creation of a National Health Service, not a National Health Insurance system. "A single comprehensive, equitable and integrated National Health System (NHS) must be created." NHI (as opposed to NHS) merits less than 1 page of that 77 page document.

NHI is mentioned as a possible way to deal with the problems in medical schemes. A committee of enquiry was to be formed to consider possible structures for an NHI under the following principles<sup>20</sup>:

- "The current medical schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system.
- Membership would be compulsory for all formal sector employees and their dependants.
- Schemes which form part of the NHI should be prohibited from excluding any member (e.g. on the basis of high risk).
- The basic package of care to be covered by the NHI should be statutorily defined.
- Contributions to cover the basic package would be income related, probably determined centrally, and should be jointly paid by employers and employees.
- This contribution revenue (covering the basic package) should be pooled in a central equalisation fund, out of which every scheme would be paid in terms of its overall risk profile i.e. a risk adjusted capitation fee.
- Existing health insurance companies and medical schemes would be free to offer "top-up" cover for services not covered in the NHI essential package.
- The long term goal would be for all citizens, including the unemployed, to be covered under the NHI system."

Thus what was envisaged initially seems to be a multi-tier system: a public National Health Service, alongside of which is a mandatory contributory environment for formal sector workers. This suggests that the ANC Health Plan envisaged a "substitutive" role for medical schemes under NHI. This early thinking needs to be revisited in the NHI debate in 2010.

Produced for IMSA by  
**Professor Heather McLeod**  
7 December 2009

## Resources on the IMSA Web-site

The following is available on the NHI section of the IMSA web-site: [www.imsa.org.za](http://www.imsa.org.za)

- The slides and tables used in this policy brief [PowerPoint slides].
- The ANC Health Plan of 1994 [PDF]

As the purpose of this series is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system, we would be delighted if you make use of it in other research and publications. All material produced for the IMSA NHI Policy Brief series and made available on the web-site may be freely used, provided the source is acknowledged. The material is produced under a Creative Commons Attribution-Noncommercial-Share Alike licence.



<http://creativecommons.org/licenses/by-nc-sa/2.5/za/>

## References

1. African National Congress. National Health Insurance Plan for South Africa Prepared by the Task Team on National Health Insurance on behalf of the Health and Education Sub-committee 2009. URL: [http://wikileaks.org/wiki/African\\_National\\_Congress\\_National\\_Health\\_Insurance\\_plan%2C\\_June\\_2009](http://wikileaks.org/wiki/African_National_Congress_National_Health_Insurance_plan%2C_June_2009)
2. African National Congress. National Health Insurance Policy Proposal: Prepared by the Health and Education Sub-committee and presented to the ANC National Executive Committee 13 July; 2009. URL: [http://wikileaks.org/wiki/African\\_National\\_Congress\\_National\\_Health\\_Insurance\\_plan%2C\\_July\\_2009](http://wikileaks.org/wiki/African_National_Congress_National_Health_Insurance_plan%2C_July_2009)
3. African National Congress. National Health Insurance: A Unified, Equitable and Integrated National Health System that benefits all South Africans *ANC Today*. Vol 9 No.29. Johannesburg: African National Congress; 2009. URL: <http://www.anc.org.za/ancdocs/anctoday/2009/at29.htm>
4. McLeod H. Expanding Health Insurance Coverage *National Health Insurance Policy Brief 2: Innovative Medicines South Africa*; 2009. URL: [http://www.innovativemedicines.co.za/national\\_health\\_insurance\\_library.html](http://www.innovativemedicines.co.za/national_health_insurance_library.html)
5. Van der Berg S, McLeod H. Crude NHI plan threatens to make a bad situation worse *Business Day*; 2009. URL: <http://www.businessday.co.za/articles/Content.aspx?id=80604>
6. Development Bank of South Africa. The National Health System: A Roadmap for Reform; 2008. URL: [http://www.innovativemedicines.co.za/files/Library/NHI/national%20health%20insurance%20in%20sa/Health\\_Strat\\_DBSA\\_Aug2008\\_Brief\\_v2.3.pdf](http://www.innovativemedicines.co.za/files/Library/NHI/national%20health%20insurance%20in%20sa/Health_Strat_DBSA_Aug2008_Brief_v2.3.pdf)
7. McIntyre D, Van den Heever A. Social or National Health Insurance. In: Harrison S, Bhana R, Ntuli A, eds. *South African Health Review 2007*. Durban: Health Systems Trust; 2007. URL: <http://www.hst.org.za/publications/711>
8. Council for Medical Schemes. Report of the Registrar of Medical Schemes, 2008/2009. Pretoria; 2009. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
9. Health Economics Unit UCT. The Public-Private Health Sector Mix in South Africa *HEU Information Sheet - Health Care Financing* 2009. URL: <http://heu-uct.org.za/research/publications/information-sheets/>
10. Mander M, Ntuli L, Diederichs N, Mavundla K. Economics of the Traditional Medicine Trade in South Africa. In: Harrison S, Bhana R, Ntuli A, eds. *South African Health Review 2007*. Durban: Health Systems Trust; 2007. URL: <http://www.hst.org.za/publications/711>
11. Department of Health. Inquiry into the Various Social Security Aspects of the South African Health System: Policy Options for the Future; 2002. URL: <http://www.doh.gov.za/docs/reports/2002/inquiry/index.htm>
12. Ministerial Task Team on Social Health Insurance. Social Health Insurance Options: Financial and Fiscal Impact Assessment. Pretoria: Unpublished technical report to the Department of Health; 2005. URL: <http://www.innovativemedicines.co.za/files/Library/NHI/national%20health%20insurance%20in%20sa/MTT%20Fiscal%20Impact%20Report%20June%202005%20vF.pdf>
13. McLeod H, Grobler P. The role of risk equalization in moving from voluntary private health insurance to mandatory coverage: the experience in South Africa. In: Chernichovsky D, Hanson K, eds. *Advances in Health Economics and Health Services Research*. Vol 21: Innovations in Health System Finance in Developing and Transitional Economies: Emerald Books; 2009. URL: <http://www.ozdov.com/pdfs/AHEHSR%20vol%2021%20disc%20leaflet.pdf>
14. McIntyre D, McLeod H, Thiede M. Comments on the National Treasury Discussion Document on the Proposed Tax Reforms Relating to Medical Scheme Contributions and Medical Expenses. ; 2005.

15. Hussey P, Anderson GF. A comparison of single- and multi-payer health insurance systems and options for reform. *Health Policy*. 2003;66:215-228.  
URL: <http://ideas.repec.org/a/eee/hepoli/v66y2003i3p215-228.html>
16. Kirigia JM, Preker A, Carrin G, Mwikisa, Diarra-Nama CAJ. An overview of health financing patterns and the way forward in the WHO African Region. *The East African Medical Journal*. 2006;83. URL:  
[http://www.who.int/entity/health\\_financing/documents/eamj-health\\_financing\\_africa.pdf](http://www.who.int/entity/health_financing/documents/eamj-health_financing_africa.pdf)
17. World Health Organization. Sustainable health financing, universal coverage and social health insurance. Resolutions and Decisions of the Fifty-eighth World Health Assembly 2005.  
URL: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA58/WHA58\\_33-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf)
18. Organization for Economic Co-operation and Development. *Private Health Insurance in OECD Countries*; 2004. URL:  
[http://www.oecd.org/document/10/0,3343,en\\_2649\\_37407\\_33913226\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/10/0,3343,en_2649_37407_33913226_1_1_1_1,00.html)
19. Barr N. Towards a 'third way' : rebalancing the role of the state. *New Economy*. 1998;5:71-76.  
URL: <http://dx.doi.org/10.1111/1468-0041.00017>
20. African National Congress. A National Health Plan for South Africa. Johannesburg: African National Congress; 1994.  
URL: <http://www.anc.org.za/show.php?doc=ancdocs/policy/health.htm>