

# NHI in South Africa: 1940 to 2008

*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 background brief provides resources on the debate around mandatory insurance in South Africa from the 1940s up to December 2008. The major focus is on the development of policy since the African National Congress (ANC) Health Plan of 1994. A separate background brief covers NHI developments in 2009. These set the scene for the series of policy briefs on aspects of the National Health Insurance debate.

## 1. Terminology: SHI or NHI?

There is often confusion about the terminology: is it Social Health Insurance or National Health Insurance? Figure 1 below, adapted from the Taylor Committee process in 2002, illustrates where mandatory insurance fits in the scheme of social security for healthcare. The Taylor Committee argued that South Africa should move away from means-tested benefits to universal benefits wherever possible. Voluntary contributory healthcare and retirement should both become mandatory contributory systems. Taylor found that “of countries at comparable levels of development, South Africa is unusual in not mandating cover”.

Department of Social Development (2002). Transforming the Present - Protecting the Future. 2002. Pretoria: Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa.

URL: <http://www.sarpn.org.za/CountryPovertyPapers/SouthAfrica/march2002/report/index.php>

The usual distinction made between Social Health Insurance and National Health Insurance is as follows:

- **Social Health Insurance (SHI)**: only those who contribute are entitled to benefits. Contributors may be all employed people, or defined groups in certain industries or all taxpayers.
- **National Health Insurance (NHI)**: usually the same taxpayers would be the contributors but everyone would be entitled to benefits.

However this technical distinction is very blurred in practice. Some technically social systems are called “National Health” and vice versa:

- **Germany** has a system known by the abbreviation SHI which means Statutory Health Insurance and which covers the entire population.
- **Indonesia** is implementing a National Health Insurance scheme where only contributors are initially covered and gradual incorporation of other groups is envisaged.

The name adopted for mandatory insurance is a question of local preference and often reflects the values of the society.

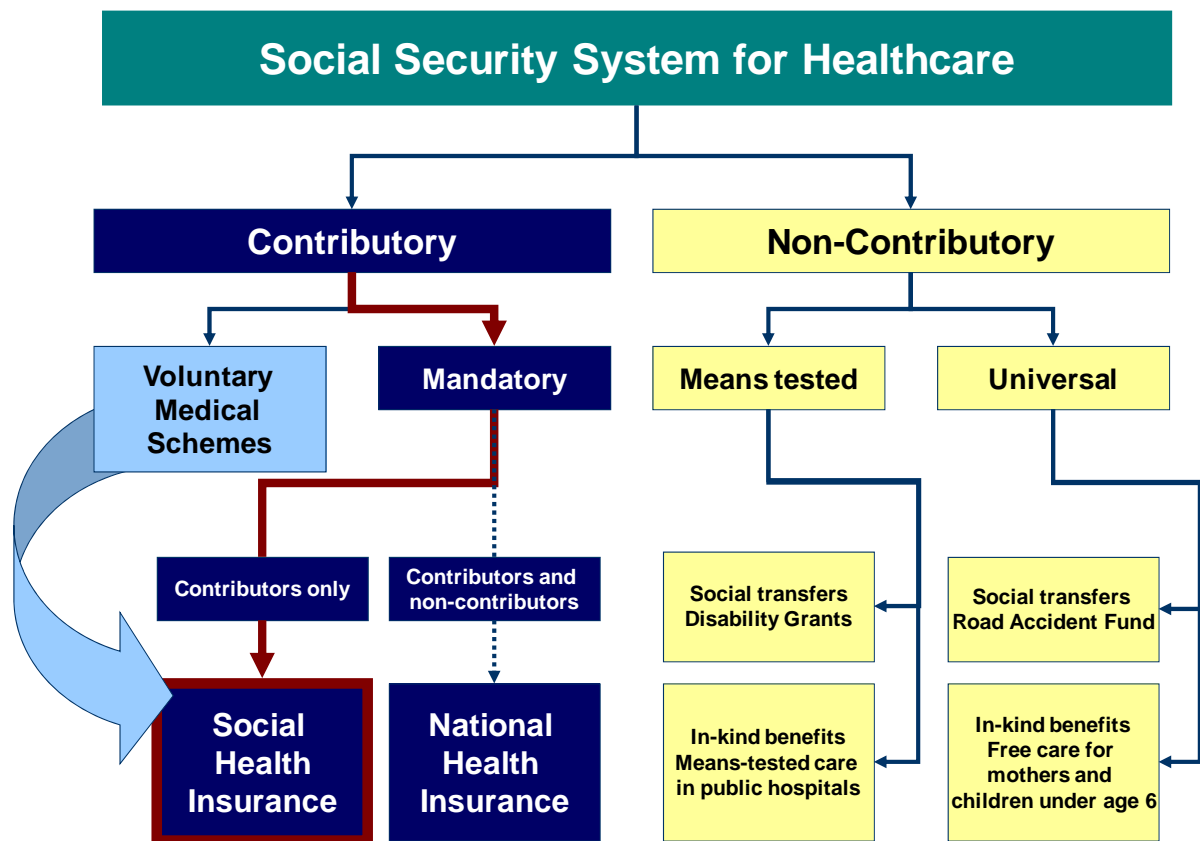


Figure 1: The Social Security System for Healthcare

In South Africa the proposals in the mid-1990s were called “National Health Insurance”. What was essentially the same system was called “Social Health Insurance” from about 2002 onwards. The terminology reverted to “National Health Insurance” in the ANC documents emerging in December 2007 from the Polokwane conference.

Prof Di McIntyre and Alex van den Heever argue that we should avoid NHI or SHI as politically-loaded terms and instead use the terminology “**mandatory health insurance**”. This recognises that there is in fact substantial common ground in the proposals.

McIntyre, D., & Van den Heever, A. (2007). Social or National Health Insurance. In S. Harrison, R. Bhana & A. Ntuli (Eds.), *South African Health Review 2007*. Durban: Health Systems Trust.

URL: [http://www.hst.org.za/uploads/files/chap5\\_07.pdf](http://www.hst.org.za/uploads/files/chap5_07.pdf)

URL for whole SAHR 2007: <http://www.hst.org.za/publications/711>

In slides presented to the Board of Healthcare Funders in November 2008, Prof Di McIntyre argues that National Health Insurance “Could be anything / take any form; (and) involves mandatory pre-payment. (The) key objective is to achieve universal coverage.”

Presentation: National health insurance in South Africa: Quo vadis medical schemes

URL: <http://www.bhfglobal.com/bhf-policy-conference-12-november-2008>

## 2. History of National Health Insurance in South Africa

### 2.1 A National Health Service attempted in the 1940s

The WHO tells of the attempted introduction of a National Health Service in South Africa in the 1940s, saying "A scheme for a national health service broadly similar to the British model was proposed in South Africa in 1944, comprising free health care and a network of community centres and general practitioners as part of a referral system, but was not implemented."

(World Health Organization (2000). *The World Health Report 2000: Health Systems: improving performance* Geneva. p13 URL: <http://www.who.int/whr/2000/en/index.html> )

Prof Anne Digby has written a very interesting paper on the reforms in South Africa in the 1940s, contrasting them with the reforms that created the National Health Service in the UK at the same time. The role of vested interests in influencing the implementation of NHI is a cautionary tale.

Digby, A. (2008). 'Vision and Vested Interests': National Health Service Reform in South Africa and Britain during the 1940s and Beyond. *Social History of Medicine*, 21(3), 485-502. URL: <http://shm.oxfordjournals.org/cgi/content/abstract/21/3/485>

"Both Britain and South Africa considered major health reforms during the 1940s and there was mutual interest in the ideas being generated. In South Africa, the Report of the National Health Services Commission of 1944 advocated a national health service based on health centres that would integrate curative, preventive and promotive work. Parallel with this were plans by the provinces for free hospital treatment. Scarce finance, together with political and medical vested interests, meant that the health centre ideal only survived in minor form. In Britain, a free national health service was created in 1948, in which a reformed structure of hospitals was central, and early plans for health centres were marginalised. In each country, limited financial resources and vested interests- in the form of powerful medical professional associations or (in the case of South Africa) of provincial administrations-delayed, scaled down or reshaped the original reforming vision."

### 2.2 Proposals from 1994 to 1999

The current National Health Insurance reform has its origins in the ANC Health Plan of 1994 which included the introduction of a mandatory insurance system. This key document is still used extensively to guide the direction of reforms throughout the health system.

African National Congress (1994). *A National Health Plan for South Africa* Johannesburg: African National Congress. URL: <http://www.anc.org.za/show.php?doc=ancdocs/policy/health.htm>

Subsequent committees of inquiry confirmed the need for the reform of healthcare financing:

- 1994: Health Care Finance Committee
- 1995: Committee of Inquiry into National Health Insurance
- 1997: Department of Health SHI Working Group
- 2002: Taylor Committee of Inquiry into Social Security
- 2004/5: Ministerial Task Team for Implementing SHI.

The 1995 Committee of Inquiry, led by Dr Jonny Broomberg and Dr Olive Shisana, confirmed the principles in the ANC Health Plan and provided more detail of the intended role of medical schemes in NHI.

Broomberg, J., & Shisana, O. (1995). Restructuring the National Health System for Universal Primary Health Care. Report of the Committee of Inquiry into a National Health Insurance System. Executive Summary. June 1995. [can be downloaded from IMSA web-site]

The Department of Health White Paper of 1997 provides material on the whole health system and a draft document in the same year provided detail on the role of the private sector in healthcare financing.

Department of Health (1997). White Paper for the Transformation of the Health System in South Africa. April 1997. Pretoria.

URL: [http://www.doh.gov.za/docs/policy/white\\_paper/healthsys97\\_01.html](http://www.doh.gov.za/docs/policy/white_paper/healthsys97_01.html)

Department of Health (1997). Reforming Financing of Private Health Care in South Africa: The Quest for Greater Access and Efficiency. A Draft Policy Document. August 1997. Pretoria. [can be downloaded from IMSA web-site]

### 2.3 Social Security Reform and the Taylor Committee of 2002

The Taylor Committee Report of 2002 provides a vision for the transformation of all aspects of social security, including retirement reform and healthcare reform. This is an important document and the recommendations are still being implemented. The section on healthcare is only some 7 pages in a 190 page document. More detail on the healthcare section is provided in the Department of Health submission to the Taylor Committee, which is some 180 pages in its own right. That document has a useful history of the public and private sectors, an assessment of the challenges and recommendations for comprehensive reform.

Department of Social Development (2002). Transforming the Present - Protecting the Future. 2002. Pretoria: Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa. Previously available on DoSD web-site. [can be downloaded from IMSA web-site]

Department of Health (2002). Inquiry into the Various Social Security Aspects of the South African Health System: Policy Options for the Future. 14 May 2002. Previously available on DoSD web-site. [can be downloaded from IMSA web-site]

### 2.4 Towards Implementation: 2003 to 2007

The Department of Health established two Consultative Task Teams followed by the Ministerial Task Team to look at detailed aspects of the implementation of Social Health Insurance. The Consultative Task Team reports and the International Review Panel assessment are in the public domain. However none of the many Ministerial Task Team reports were placed in the public domain and only the last report is included in the list of documents below.

Department of Health (2003). Opening Address to the Consultative Forum on Risk Equalisation by Dr Ayanda Ntsaluba, Director-General, Department of Health. 10 July 2003. Midrand. [Document can be downloaded from IMSA web-site]

McLeod, H., Matisonn, S., Fourie, I., Grobler, P., Mynhardt, S., & Marx, G. (2004). The Determination of the Formula for the Risk Equalisation Fund in South Africa. January 2004. Pretoria: Prepared for the Risk Equalisation Fund Task Group on behalf of the Formula Consultative Task Team.

URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

Roux, A. (2004). The Funding of the Risk Equalisation Fund in South Africa. Prepared for the Risk Equalisation Fund Task Group on behalf of the Subsidy Consultative Task Team January 2004. Previously available on <http://www.medicalschemes.com>

Armstrong, J., Deeble, J., Dror, D. M., Rice, N., Thiede, M., & Van de Ven, W. P. M. M. (2004). The International Review Panel Report to the South African Risk Equalization Fund Task Group. 16 February 2004. Pretoria.

URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

Ministerial Task Team on Social Health Insurance (2005). Social Health Insurance Options: Financial and Fiscal Impact Assessment. Unpublished technical report to the Department of Health. June 2005.

Draft legislation to implement the Risk Equalisation Fund, as a first step in the development of Social Health Insurance, was gazetted for submission to parliament in 2008. There were substantial objections to the Medical Schemes Amendment Bill (2008) from organised labour and civil society organisations and the bill was not tabled in parliament. The progress of bills through parliament can be followed at [http://www.parliament.gov.za/live/content.php?Category\\_ID=72](http://www.parliament.gov.za/live/content.php?Category_ID=72)

## 2.5 Summaries and Commentaries on the Process

Prof Di McIntyre and Alex van den Heever provide a summary of the history of NHI from the 1940s to 2005. The paper is particularly useful as a summary of developments and for providing an understanding of proposals in terms of the four functions in healthcare financing: revenue collection, pooling, purchasing and delivery. They describe the “considerable discussion and sometimes very heated debates” and outline the core features of each of the proposals.

McIntyre, D., & Van den Heever, A. (2007). Social or National Health Insurance. In S. Harrison, R. Bhana & A. Ntuli (Eds.), *South African Health Review 2007*. Durban: Health Systems Trust.

URL: [http://www.hst.org.za/uploads/files/chap5\\_07.pdf](http://www.hst.org.za/uploads/files/chap5_07.pdf)

URL for whole SAHR 2007: <http://www.hst.org.za/publications/711>

“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.” “South Africa has missed previous windows of opportunity to initiate a mandatory health insurance scheme. ... 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.”

It is useful to stand back from the detail of the reforms and understand the factors that influence the implementation of reforms. Two papers are highly recommended:

McIntyre, D., Doherty, J., & Gilson, L. (2003). A tale of two visions: the changing fortunes of Social Health Insurance in South Africa. *Health Policy Plan*, 18(1), 47-58.

URL: <http://heapol.oxfordjournals.org/cgi/reprint/18/1/47>

Thomas, S., & Gilson, L. (2004). Actor management in the development of health financing reform: health insurance in South Africa, 1994-1999. *Health Policy Plan*, 19(5), 279-291.

URL: <http://heapol.oxfordjournals.org/cgi/reprint/19/5/279>

“Health reform is inherently political. Sound technical analysis is never enough to guarantee the adoption of policy. Financing reforms aimed at promoting equity are especially likely to challenge vested interests and produce opposition. This article reviews the health insurance policy development in South Africa between 1994 and 1999. Despite more than 10 years of debate, analysis and design, no set of social health insurance (SHI) proposals had, by 1999, secured adequate support to become the basis for an implementation plan. In contrast, proposals to re-regulate the health insurance industry were speedily developed and implemented at the end of this period. The processes of actor engagement and management, set against policy goals and design details, were central to this experience.”

### 3. Health System Reform circa 2005

This is an extract from "Introduction to National Health Insurance" prepared for IMSA in May 2008. [can be downloaded from IMSA web-site]. See end of section for the download of the final document prepared by the **Ministerial Task Team on Social Health Insurance** in June 2005.

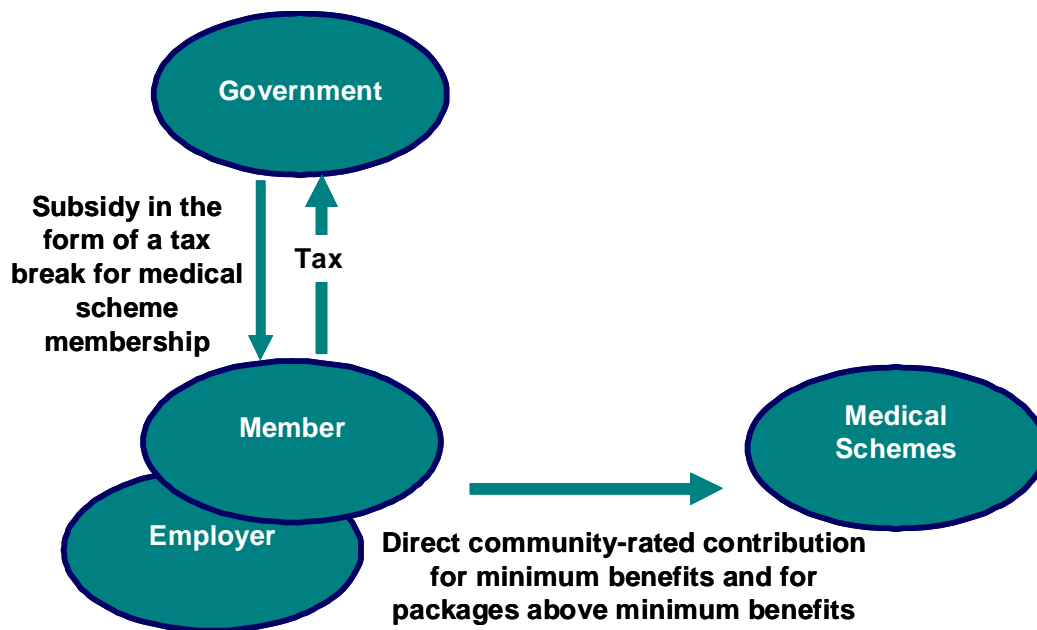
Reform of medical schemes to prepare them for mandatory insurance was planned throughout the 1990s and culminated in the completely revised Medical Schemes Act, No. 131 of 1998. This provided for improved governance of medical schemes and for the re-introduction of three key policy issues which enhance the risk pooling function of schemes:

- **Open enrolment**: open schemes have to accept anyone who wants to become a member at standard rates.
- **Community-rating**: everyone must be charged the same standard rate, regardless of age or state of health (i.e. charging by risk or risk-rating is not allowed). However, the current implementation applies to each benefit option in each scheme rather than the scheme as a whole. Future changes will see community-rating applying to the industry as a whole.
- **Prescribed Minimum Benefits (PMBs)**: a minimum package that must be offered by all schemes. Beneficiaries must be covered in full for these conditions with no limits or co-payments. The PMB package is a list of some 270 diagnosis-treatment pairs (DTPs) primarily offered in hospital (introduced January 2000); all emergency medical conditions (defined January 2003); diagnosis, treatment and medicine according to therapeutic algorithms for 25 defined chronic conditions on the Chronic Disease List (CDLs) (introduced January 2004).

In order to manage care for the Prescribed Minimum Benefit, schemes may insist on the use of a contracted network of providers (Designated Service Providers or DSPs) and formularies of medicines (lists of cost-effective medicines that the scheme will reimburse). Schemes are in theory able to negotiate fees with healthcare providers but have struggled against the concentration of power amongst providers, particularly the hospital groups in recent years. In practice most schemes adopt fee schedules which are some percentage of the National Health Reference Price List (NHRPL). The process by the Department of Health for determining the annual NHRPL has attracted much heated response from providers and there is general agreement that reimbursement methods need to move more towards per case and capitation forms of payment. Under capitation, instead of paying a fee for every service or visit, the healthcare provider is paid a fixed sum in advance for all the lives covered, whether they are healthy or need treatment.

At present, members (sometimes supported by an employer) make direct contributions to medical schemes as shown in the figure below. The contributions are community-rated and cover the legislated PMBs and optional amounts of care above the PMBs. There is a tax subsidy for private healthcare which favours the highest income but gives no subsidy to those in medical schemes who earn below the tax threshold (R3,833 per month for 2008/9 tax year for those under age 65 and R6,166.67 per month for those over age 65).

The tax break has reduced the sensitivity of higher income groups to the increases in contributions because until 2006 the subsidy escalated at the same rate as contributions. There is generally low awareness amongst individuals of the tax incentive for medical scheme membership. However the total amount of this tax break is large: in 2005 it was estimated as costing R10.1 billion which was some 20% of total government spending on public health services in that year.



**Figure 2: Current Flow of Funds in Voluntary Medical Schemes**

In January 2004 the Minister of Health stated there were three issues on the unfinished reform agenda toward implementing Social Health Insurance (SHI):

- The introduction of **risk-adjusted cross-subsidies**. This will effectively enforce community rating across all medical schemes so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join. This will be accomplished through a central Risk Equalisation Fund.
- The introduction of **income-based cross-subsidies**. This de-links the purchase of healthcare from family affordability concerns. It enforces the primary solidarity mechanism under which people receive a common package of benefits according to healthcare needs and contribute to healthcare on the basis of their ability to pay.
- The creation of a **mandatory environment**. People earning above a certain amount would be required to contribute to mandatory health cover.

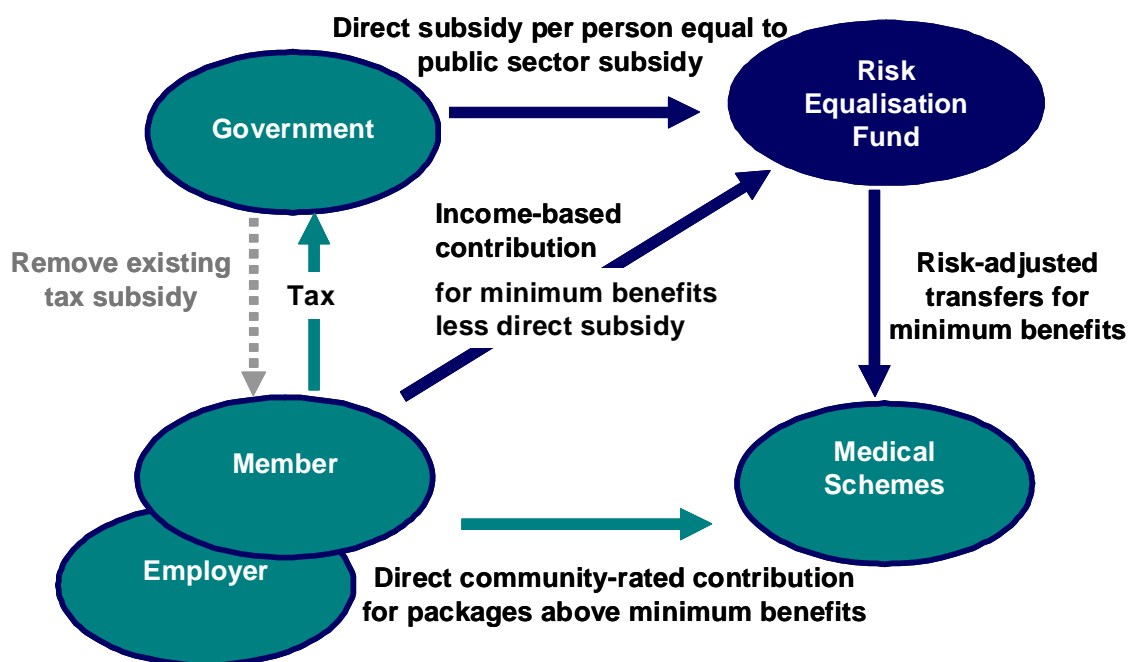
The first reform as envisaged by the Department of Health is to establish a system of risk equalisation between medical schemes via a new statutory body, the Risk Equalisation Fund (REF). In the absence of risk equalisation, schemes are incentivised to “risk select” or “cream-skim” i.e. to seek younger and healthier lives and design packages that are not as attractive to those with chronic disease. A scheme with a younger and healthier profile has a lower community rate (contribution) than one with older and sicker members. The price of healthcare thus depends on the option or scheme you join.

The effect of risk equalisation is to ensure that everyone across all medical schemes pays a similar community rate for the same package of benefits (the PMBs). The community rate will no longer be influenced by age and disease, but only by the efficiency of the medical scheme in purchasing and delivering care to its members.

The primary objective of the Risk Equalisation Fund is thus to protect open enrolment and community rating. South Africa is unusual internationally in having open enrolment, community rating and minimum benefits without risk equalisation at present. Other countries with risk equalisation in a

competitive market include Germany, Switzerland, Belgium, the Netherlands, Israel, Australia and the United States of America. Risk equalisation techniques are also present in many other systems like the United Kingdom where it is used to equalise risk between regions of the country in the National Health System (NHS).

It is expected that the REF in South Africa will equalise the expected risk faced by all medical schemes on the basis of several risk factors: age, gender (not yet implemented), maternity events, numbers with one of 26 chronic diseases and numbers with multiple chronic diseases.



**Figure 3: Envisaged Flow of funds under Mandatory Health Insurance**

The second reform envisaged would be to remove the existing unfair tax subsidy and replace it with a direct subsidy per person. The amount would be the same per person and equivalent to the amount being spent per head in the public sector. This would immediately provide substantial relief for lower income groups and make contributions more affordable for these families. The direct subsidy per person would be sourced from tax revenue and paid from government to the Risk Equalisation Fund. The REF would in turn make monthly risk-adjusted payments of this amount to medical schemes, as shown below.

The third reform would be to raise an income-related contribution for the difference between the price of the minimum benefit package and the public sector subsidy. This amount would be paid to the REF together with the direct subsidy per person, enabling the REF to make monthly risk-adjusted payments to medical schemes in respect of the total minimum benefit package. This income-related contribution would be mandatory for all people earning over a certain amount and would replace about half of the amounts paid directly to medical schemes at present.

It has been estimated that an income-related contribution of the order of 3-3.8% of income would be needed to cover the current definition of the minimum benefit package, depending on the income level at which contributions become mandatory.



McLeod, H. (2007). Framework for Post-Retirement Protection in Respect of Medical Scheme Contributions. In Department of Social Development (Ed.), Reform of Retirement Provisions: Feasibility Studies. Pretoria. Previously available on DoSD web-site.

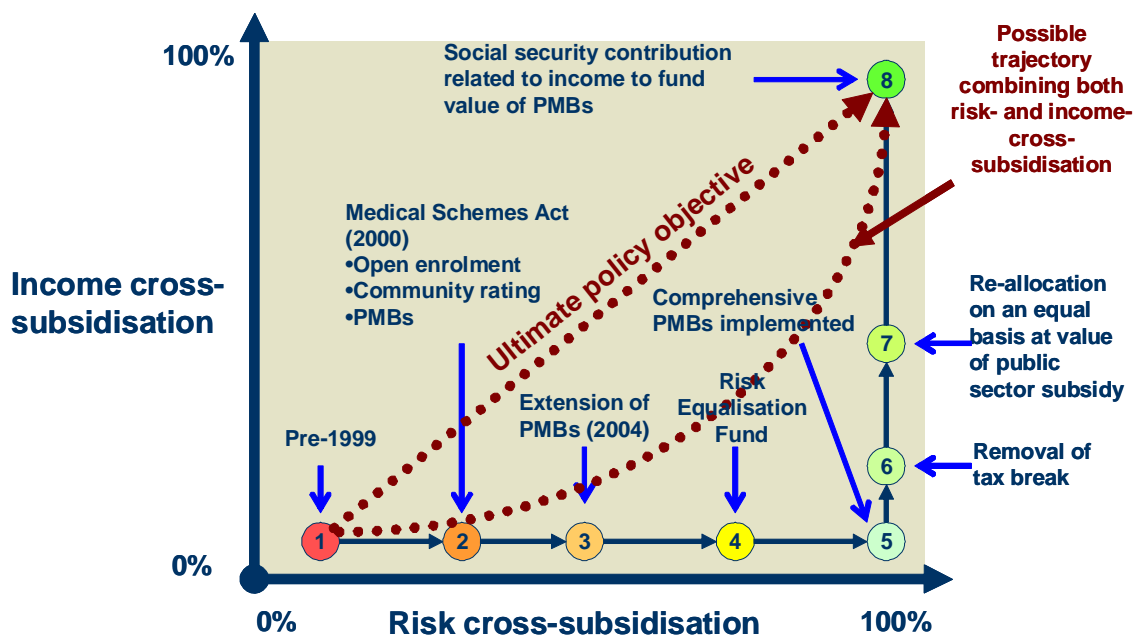
URL: <http://www.polity.org.za/article/reform-of-retirement-provisions-feasibility-studies-september-2007-2007-09-11> or URL: <http://www.treasury.gov.za/publications/other/ssrr/General%20Papers/Reform%20of%20Retirement%20Provisions.pdf>

A myth about this income-related contribution is that it is paid in addition to existing contributions to medical schemes. This is not true: it is simply another way of paying for contributions to medical schemes. Many restricted schemes already have contributions related to income. This reform would ensure that all medical scheme members contribute according to income in the same way. Direct payments to medical schemes as a whole would reduce by the amount of the direct subsidy plus the amount raised by the income-related contribution.

The amount needed to be raised to cover PMBs depends on the definition of the minimum package. Every R10 change in the cost of the PMB package for the industry increases the income-related contribution by between 0.4% and 0.6%, depending on the income threshold. The definition of the PMB package is currently the subject of a reform process initiated by the Council for Medical Schemes in conjunction with the Department of Health.

Members would still be allowed to choose packages greater than the minimum benefits, but would pay the additional amounts directly to medical schemes. These are shown in the diagram above as being on a community-rated basis but there could be some limited form of risk-rating allowed for standardized benefits above the minimum.

The diagram below indicates the policy flow from the mid 1990s to achieving a mandatory health system. Comprehensive PMBs were envisaged to include the existing definition of PMBs together with primary care.



**Figure 4: Policy Flow in Medical Schemes to achieve Mandatory Health Insurance**  
 (Source: Ministerial Task Team on SHI, July 2005, amended)

Substantial progress was made on the steps as shown above. Efforts were clustered around item 4, the establishment of the Risk Equalisation Fund, which is central to mandatory health insurance.

The last publicly-available document from the Department of Health on the issue of mandatory health insurance is thought to be dated July 2003 when the then Director-General of Health, Dr Ayanda Ntsaluba, spoke at the opening of the consultative process on the design of risk equalisation.

Department of Health (2003). Opening Address to the Consultative Forum on Risk Equalisation by Dr Ayanda Ntsaluba, Director-General, Department of Health. 10 July 2003. Midrand. [Document can be downloaded from IMSA web-site]

Substantial work has been done since 2003 on the design of the risk equalisation formula by the Formula Consultative Task Team and subsequently by RETAP, the Risk Equalisation Technical Advisory Panel. Since 2007 the technical work has been continued by the Council for Medical Schemes.

McLeod H., Matisonn S., Fourie I., Grobler P., Mynhardt S. and Marx G., (2004) The Determination of the Formula for the Risk Equalisation Fund in South Africa. Prepared for the Risk Equalisation Fund Task Group on behalf of the Formula Consultative Task Team, January 2004.

URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

RETAP (2005) Methodology for the Determination of the Risk Equalisation Fund Contribution Table [Base 2002, Use 2005]. Recommendations by the Risk Equalisation Technical Advisory Panel to the Council for Medical Schemes. Recommendations Report No. 1 of 2005. 10 February 2005. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

RETAP (2007) Methodology for the Determination of the Risk Equalisation Fund Contribution Table 2007 [Base 2005, Use 2007]. Recommendations by the Risk Equalisation Technical Advisory Panel to the Council for Medical Schemes. Recommendations Report No. 9. 17 April 2007. URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

The effect of the REF should be to substantially change the competitive dynamics between medical schemes. The intention is that funds will no longer compete on the basis of risk selection but increasingly on the basis of cost-effective delivery of healthcare. Funds that are successful at reducing the cost of delivery will retain that benefit for their members and will thus be able to lower their contributions for the minimum benefits. Funds that are not successful at lowering delivery costs to the industry community rate determined by REF would need to charge members for the difference on a community-rated basis.

The International Panel had argued for urgent implementation of the risk equalisation mechanism and the first date suggested was 2005.

Armstrong J., Deeble J., Dror D.M., Rice N., Thiede M., Van de Ven W.P.M.M. (2004) The International Review Panel Report to the South African Risk Equalization Fund Task Group. 16 February 2004.

URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=23>

For a complete history of risk equalisation development in South Africa, including RETAP reports, academic articles, official and preferred tables, see

<http://hmcLeod.moonfruit.com/#/risk-equalisation/4522627754>

Approval was obtained from Cabinet to begin shadow transfers from January 2005 with no money changing hands. The industry expected the full implementation of REF from 1 January 2007, but the legislative and capacity building process is taking much longer than expected. The targeted date for the REF implementation from which financial transfers would have taken place was 2010 but this has been delayed to an unknown future date.

The **Ministerial Task Team on Social Health Insurance** prepared some eight documents for the Department of Health and National Treasury in the course of 2004 and 2005. A final summary document was prepared for the Department of Health for Cabinet discussions and was dated June 2005. None of the reports was released in the public domain but in 2007 another government department made the final report available to some foreign and local researchers.

[Download from IMSA web-site]

In 2006, the Ministerial task Team on SHI initiated a process that was convened by the Council for Medical Schemes to consider other reforms that might result in an expansion of medical scheme membership for low income workers (the Low Income Medical Scheme or LIMS process). The stakeholder teams lead by Dr Jonny Broomberg produced extensive material on the issue. The terms of reference, evidence, final reports and stakeholder comments are available from

<http://www.medicalschemes.com/publications/publications.aspx?catid=29>

A process of reconsidering the Prescribed Minimum Benefits was begun by the Council for Medical Schemes in 2008. The documents relating to this on-going process are available from

<http://www.medicalschemes.com/publications/publications.aspx?catid=33>

The Bill for an amendment to the Medical Schemes Act of 1998, which would have established the Risk Equalisation Fund and created an enabling provision for LIMS options, was gazetted in 2008 but did not proceed through parliament.

#### 4. Health System Reform pre- and post-Polokwane

In a recent paper published in Australia entitled "South Africa: a 21st century apartheid in health and health care?" Prof Gavin Mooney and Prof Di McIntyre provide a succinct comparison of health reform ideas in South Africa pre- and post-Polokwane (The ANC Policy Conference of December 2007 was held in the city of Polokwane in Limpopo province).

Mooney, G. H., & McIntyre, D. E. (2008). South Africa: a 21st century apartheid in health and health care? *Med J Aust*, 189(11-12), 637-640.

URL: [http://www.mja.com.au/public/issues/189\\_11\\_011208/moo11135\\_fm.html](http://www.mja.com.au/public/issues/189_11_011208/moo11135_fm.html)

"Given the massive health challenges facing South Africa, and the limited capacity of the health system to meet these challenges, what are the options for change? Mandatory health insurance has been discussed since the late 1980s, but has never been implemented. This is set to change, with the ANC Policy Conference in December 2007 making a very explicit policy commitment to the "implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding". The precise nature of the proposed National Health Insurance is still the subject of discussion." ...

"Proposals in the past have focused on introducing what would in effect be a social health insurance; that is, one that only covered health care for those who contributed. The intention was to regulate medical schemes to move them away from risk-rated contributions, and to introduce both a prescribed minimum-benefit package and a risk-equalisation fund between individual schemes. This would introduce risk cross-subsidies (between healthy and ill South Africans), and ultimately move towards income cross-subsidies through further regulation." ...

"The major drawback of this option is that it could entrench a two-tier system. Although, over time, it is possible that mandatory insurance cover would be extended and differentials between the public and private sectors would diminish, experience in Latin American countries has demonstrated that

opposition from powerful stakeholders makes it difficult to move from social health insurance to a universal health care system. Indeed, the major rationale for considering this option was the existence of medical schemes (and private health care providers) as a powerful force in the South African health system. The appropriateness of this reform path was seen as being embedded within South Africa's historical context."

"The decision at the ANC conference has created the space for a somewhat different vision of change in the South African health system — one that focuses from the outset on achieving universal coverage by promoting income and risk cross-subsidies in the overall health system. The broad vision is to focus energies primarily on rebuilding the public health sector to the point where it once again becomes the provider of choice for the vast majority of South Africans. This would be achieved by reversing the effects of the GEAR policy, and gradually, but substantially, increasing tax funding for health services, as well as introducing a compulsory National Health Insurance contribution for all formal sector employees (those in paid employment). These funds would be pooled to promote access to publicly funded health services that benefit all the population. In this way, all South Africans would be entitled to the benefits of the National Health Insurance, as general tax revenue funding would effectively cover the contributions of those outside of the formal employment sector.

"The introduction of an explicit National Health Insurance payroll contribution would have two effects. First, it would create a sense of entitlement to publicly funded health services. Second, it would compel medical-scheme members to seriously consider whether continued medical-scheme membership is worth the additional cost.

"The value of this approach is that it would lead to an integrated funding and service provision system, with considerable income and risk cross-subsidies, and this would occur within the shortest possible time. Although the richest individuals may still choose to contribute to medical schemes in addition to their National Health Insurance payments, a visible two-tier system would be diminished, rather than reinforced and entrenched as in the social health insurance option. In addition, by holding the "strings" of the largest health care "purse" (rather than attempting to achieve this only through regulatory means), National Health Insurance is likely to be a much more powerful mechanism for controlling the fees charged by private providers. The extent to which the services of private providers are purchased by the National Health Insurance will depend on the level of public sector service capacity in particular geographical locations, as well as the extent to which private providers are willing to accept the payment rates offered by it."

## 5. Stakeholder Perspectives on NHI to end 2008

### 5.1 Public Perception

Shisana, O., Rehle, T., Louw, J., Zungu-Dirwayi, N., Dana, P., & Rispel, L. (2006). Public perceptions on national health insurance: moving towards universal health coverage in South Africa. *S Afr Med J*, 96(9), 814-818. URL:

[http://blues.sabinet.co.za/WebZ/Authorize?sessionid=0:autho=pubmed:password=pubmed2004&/AdvancedQuery?&format=F&next=images/ejour/m\\_samj/m\\_samj\\_v96\\_n9\\_a14.pdf](http://blues.sabinet.co.za/WebZ/Authorize?sessionid=0:autho=pubmed:password=pubmed2004&/AdvancedQuery?&format=F&next=images/ejour/m_samj/m_samj_v96_n9_a14.pdf)

"This paper reports on the findings of a national probability household sample of the South African population, drawn as part of the 2005 HIV/AIDS national survey, to gauge public opinion on universal health care coverage." "The majority support efforts to contain medicine costs and one-third are of the opinion that the country can provide everyone with all the needed health care and medical services. A large percentage of participants thought it more important to provide improved health care coverage even if it meant raising taxes, while a small percentage said it is better to hold down taxes despite lack of access to health care for some South Africans. Almost a quarter of participants were unable to comment on questions posed to them, indicating the need for improved public education and communication."

## 5.2 Congress of South African Trade Unions (COSATU)

COSATU/NEHAWU (2003) Submission to the Public Hearings on the Report of the Committee of Enquiry into Comprehensive Social Security System. Submitted to the Portfolio Committee on Social Development 09/10 June 2003. Available on <http://www.cosatu.org.za>

Slides on the COSATU position of July 2008 as presented to the Board of Healthcare Funders on 12 November 2008.

<http://www.bhfglobal.com/bhf-policy-conference-12-november-2008>

## 5.3 Employers Perception

The perceptions of employers were canvassed by Old Mutual in their Healthcare Survey 2005: towards Social Health Insurance.

"All 100 employers surveyed say they want to play a part in the process of transformation and in the decisions taken that affect both employer and employees. This finding contrasts sharply with the 62% of respondents who say they do not understand the impact of SHI on the healthcare industry. There is significant opportunity for engagement so that employers understand the objectives of SHI.

"The analysis of the opinions of employers regarding the proposed Health Charter indicates that they believe the most important element is the necessity for greater collaboration between the private sector and government for the good of the South African healthcare industry. Employers are sceptical about the success of the practical implementation of transformation and would like more information on the roll-out of SHI and other initiatives aimed at transforming the healthcare industry."

Old Mutual (2005) Old Mutual 2005 Healthcare Survey: towards Social Health Insurance.

<http://www.oldmutual.co.za/healthcare/Content/Services/HCSurvey.asp?NavId=2>

## 5.4 South African Medical Association (SAMA)

No policy documents available but comments or descriptions of conference proceedings found in:

**South African Medical Journal:** <http://www.samj.org.za/index.php/samj>

**Medical Chronicle:** [http://www.wilbury.co.za/mc\\_archive.html](http://www.wilbury.co.za/mc_archive.html)

## 5.5 Hospital Association of South Africa (HASA)

<http://www.hasa.co.za/>

The **HASA Annals** are produced annually and contain research articles on topics such as human resources, medical inflation and the cost of private healthcare. Complete electronic versions for earlier years are not available on the HASA web-site but a search on "Hospital Annals" produces the individual articles. Articles in the **HASA Annals 2008** can be downloaded from:

[http://www.hasa.co.za/media/uploads/about/publications/files/2009-02-26/HASA\\_Annals\\_2008\\_CONTENTS.pdf](http://www.hasa.co.za/media/uploads/about/publications/files/2009-02-26/HASA_Annals_2008_CONTENTS.pdf)

## 5.6 Board of Healthcare Funders (BHF)

The BHF held a policy conference on 12 November 2008 on National Health Insurance. Speakers included COSATU, Alex van den Heever from the Council for Medical Schemes and Prof. Di McIntyre, the Research Chair: "Health & Wealth". The three presentations can be downloaded from

<http://www.bhfglobal.com/bhf-policy-conference-12-november-2008>

## 5.7 Human Sciences Research Council (HSRC)

**Financing South Africa's National Health System through National Health Insurance: Possibilities and Challenges** (Colloquium Proceedings). Compiled by Claire Botha and Michael Hendricks for the HSRC Policy Analysis Unit. 2008.

URL: <http://www.hsrcpress.ac.za/product.php?productid=2240>

"The provision of universal access to healthcare, a right enshrined in the South African Constitution, is the responsibility of government. Although much progress has been made towards the creation of a national health system which makes 'access to health for all' a reality, much remains to be done."

"As a means to facilitate debate on the subject, the Policy Analysis Unit of the Human Sciences Research Council, hosted a colloquium on 'Health within a comprehensive system of social security', under the auspices of the South African National Liaison Committee of Unesco's Management of Social Transformation Programme. The main purpose of the colloquium was to initiate policy dialogue and critical discussion on how health services are accessed, provided and funded - and to formulate ideas, views and recommendations that could be presented to those involved in health policy development. This book contains the keynote addresses and a summary of deliberations emerging from the colloquium."

"Section A of the book contains the opening address by Dr Olive Shisana, President and CEO of the HSRC, and the keynote address by the Minister of Health, Dr Manto Tshabalala-Msimang, followed by a discussion of the context for policy debates on health within a comprehensive system of social security.

Section B provides a synthesis of the colloquium proceedings, beginning with a brief summary of inputs and discussions under the four key themes: the reform path since 1994; critical options for health within the context of a comprehensive system of social security; local and international evidence on health system models; health systems reform and stakeholder engagement. The section concludes with a brief outline of key issues discussed in the areas of healthcare provision, healthcare funding and the purchasing of healthcare. Section C provides recommendations for improving implementation, and taking the process of policy development forward."

## 5.8 Development Bank of South Africa (DBSA)

<http://www.dbsa.org/Pages/default.aspx>

A document resulting from the "Roadmap for Reform" process was prepared but is not on the DBSA web-site. A near-final version that was handed out at a meeting of stakeholders in August 2008 is available [download from the IMSA web-site].

"The implementation of a NHI structure will not instantly eliminate tiering as South Africa is inhibited by its socioeconomic context, its level of development, and the weak public sector health administrations. However, the existence of the NHI structure will automate the evolution of a predominantly single-tier system as the economy enlarges and formal employment increases.

It is furthermore important to understand that the existence of health insurance within a developing country context is inevitable and desirable. South Africa has the advantage of a well regulated medical scheme system that can form an important component of the overall system of social security. Consistent with health systems internationally, the considered incorporation of regulated private health insurance into the overall system of social security is well accepted and essential to the achievement of health policy goals.

A necessary consideration for health systems reform is to avoid unravelling existing institutional arrangements and attempting to replace them with new ones. Successful reform of any complex system always builds on existing institutions whether in the private or public sector.

The framework and vision provided in this Roadmap therefore focuses on the priority areas for intervention, including structural reform. The challenge is however considerable, and strong leadership, extensive mobilisation and public participation will be needed to see significant change within a five-year period. Without this leadership the reforms will fail to achieve their goals irrespective of the quality of the plan.”

Produced for IMSA by

**Professor Heather McLeod**

24 October 2009

## Resources on the IMSA Web-site

This brief is a collation of the IMSA NHI web-site pages on this background topic. The web-site has additional documents that can be downloaded: [www.imsa.org.za](http://www.imsa.org.za)

The policy with respect to documents prepared by other organisations is to use a link to their web-site wherever possible. However over time some documents are removed, web-sites are redesigned or organisations change. Examples where the original is no longer available are many of the historical documents from the Department of Social Development. If another site is found that hosts the document we will gladly reinstate a link to that URL.

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.



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**Innovative Medicines South Africa (IMSA)** is a pharmaceutical industry association promoting the value of medicine innovation in healthcare. IMSA and its member companies are working towards the development of a National Health Insurance system with universal coverage and sustainable access to innovative research-based healthcare.

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