

National Health Insurance in South Africa

An Introduction for Journalists



Prepared for Innovative Medicines South Africa

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with the support of Bathabile Holdings

11 May 2008



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1. Imminent Reform of Healthcare and Retirement in South Africa

On 11 February 2008, Minister Zola Skweyiya, on behalf of the Social Cluster¹ of ministers, made the following announcement in parliament²:

“We recognise that we are at the beginning of a long journey to a truly united, democratic and prosperous South Africa, in which the value of all citizens is measured by their humanity, without regard to race, gender and social status. Inspired by the Freedom Charter and the principles enshrined in the Reconstruction and Development Programme, we continue with our social transformation programme, informed by the democratic principles of the people-centred and people-driven state and a value system based on human solidarity. These pillars are the attributes of a caring society and it beckons us to forge a social compact - made up of all races - that has, as its central objective a social policy, the preservation and development of human resources and ensuring social cohesion.”

“On ... comprehensive social security:

* Government must continue with its plans towards a comprehensive social security system, through consolidation and ongoing review of all social security measures such as (the) Unemployment Insurance Fund (UIF) and social grants.

* Government has taken bold steps in establishing a **National Health Insurance Scheme** and must finalise its plans within the next twelve months.” (emphasis added)

“South Africa does not have a fully developed second pillar³ or system of social insurance. History and experience have proved that the role of the State is critical in providing the platform for a social insurance system to ensure the pooling of risks and to achieve social solidarity objectives. The State cannot simply assume the role of consumer protection and watch failures of private providers such as what we are now witnessing in the unfolding Fidentia saga.”

“On health insurance, government has increased the number of people contributing to medical aid schemes, has set up its own employee medical scheme and has also introduced measures to prohibit adverse selection by the private industry.”

¹ Includes Departments of Social Development, Health, Education, Housing, Land Affairs, Arts and Culture and related functions.

² Skweyiya (2008) Debate on State of the Nation address (11/02/2008).

³ Typically social security systems incorporate three pillars:

First pillar: a universally available basic benefit to which all citizens are entitled on a non-contributory basis. Funding is typically out of general taxes.

Second pillar: this is a contributory environment over-and-above the first pillar, where income protection is a core focus. It is characterized by strong mechanisms to assure social solidarity. This protects minimum levels of cover where income earners are willing and able to pay more toward their social security than is provided for by the first pillar benefit.

Third pillar: this pillar involves discretionary insurance, over-and-above the minimum levels regarded as essential. Here individuals are left to make decisions completely at their discretion. Government is however still required to ensure that basic consumer protection is in place.

Skweyiya continued: “The President also referred to the urgent need to reform the country's retirement provisions. ... Our view is that government needs to make the participation in retirement vehicles mandatory, to prohibit early withdrawals, provide for portability and preservation of funds, and set up institutional arrangements for delivery. The reform must meet international best practice criteria of adequate coverage of employed persons and affordability for individuals and government. It must also be fiscally and financially sustainable and robust, and there must be better replacement rates that protect the poor. The system must link benefits to contributions of employees and provide for ancillary benefits of disability, survivors, and old age medical requirements (emphasis added). My colleague, the Minister of Finance will address the financing aspects”

The comprehensive review of social security by the Taylor Committee in 2002 said⁴:

“South Africa has a highly developed private social insurance market offering life, disability, health, property and casualty cover as well as a range of retirement benefits. ... the insurance is either voluntary or, at most, cover is a matter of the employment contract. Of countries at comparable levels of development, South Africa is unusual in not mandating cover.” (emphasis added)

The Taylor Committee recommended that retirement and healthcare both become mandatory systems of social insurance. After some delay, we are now seeing the practical implementation of those recommendations in both retirement and healthcare. The speed of implementation is also now fuelled by changes in the political landscape post-Polokwane. We should expect major announcements in both areas before elections in 2009.

This document has been prepared to assist employers in understanding what a National Health Insurance system might mean in order to engage in debate at NEDLAC and in other forums. The document attempts to dispel some of the myths about the reforms that have built up in the absence of adequate communication.

2. The South African Healthcare System

The South African health system has long been characterised by extreme inequalities in the allocation of financial and human resources. During the *apartheid* years the inequalities were established on the basis of race but despite a strong commitment since 1994, progress has been limited and income inequality has worsened. As a result, inequalities in healthcare are increasingly related to socio-economic class rather than race^{5,6}.

South Africa has a health delivery system which is a mix of robust private sector, struggling public sector and some non-governmental not-for-profit organisations. The National Health Act of 2003 makes it clear that all of these form part of the national health system under the stewardship of the Minister of Health.

⁴ *Transforming the Present – Protecting the Future*, Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa, May 2002, page 46.

⁵ South African Health Review, 2007, Editorial

⁶ South African Health Review, 2007, Chapter 3, *Health Care Financing and Expenditure*

Private health insurance cover, delivered through medical schemes, is voluntary and serves only the 14.8% of the population with higher incomes. Healthcare is delivered to these members predominantly in the private sector which is well developed, resource intensive and highly specialised⁵. It is estimated⁷ that 21.0% of the population are not covered by health insurance but prefer to use private primary care doctors and pharmacies on an out-of-pocket basis. This group is almost entirely dependent on the public sector for specialist and hospital care. The remaining 64.2% of the population are dependent on the public sector for all their conventional healthcare services.

It is a persistent myth that people who use all their medical scheme benefits can use the public sector at no cost. User fees are charged in the public system and those earning an income of R6,000 per month or more are required to pay in full at a tariff similar to private rates. However the exemption policy has been liberally applied and bills were not always followed up in the past, allowing this myth to persist.

Approximately 60% of the total expenditure on healthcare in the country flows via private intermediaries and only 40% through the public sector. The major difficulty with the over-resourcing of private health insurance and under-resourcing of the public sector is that healthcare practitioners have been attracted to the more lucrative private system. The table below highlights the inequitable distribution of healthcare personnel.

Table 1: Healthcare Coverage, Expenditure and Resourcing in South Africa in 2005
[from sources in SAHR 2007]

	Private Health Insurance	Some Private + Public	Public Sector
Delivery of healthcare	Private primary care and private hospitals	Private primary care and public hospitals	Public primary care and public hospitals
Population covered	7.0 million	9.8 million	30.2 million
Proportion of population	14.8%	21.0%	64.2%
Per capita expenditure per beneficiary per annum	R9,500	R1,500	R1,300
Proportion of total expenditure	55.0%	12.3%	32.7%
Population per primary care practitioner	(243)*	588	4,193
Population per pharmacist	(765)*	1,852	22,879
Population per specialist	470	10,811	
Population per nurse	102	616	
Population per hospital bed	194	399	
Proportion of population using Traditional Medicine	not covered	72.0%	informal and isolated integration
Population per Traditional Medicine practitioner		182	

* estimates in brackets are if only used by private health insurance

⁷ South African Health Review, 2007, Chapter 5, *Social or National Health Insurance*

A seldom-reported part of the health system is the use of Traditional Medicine (TM) practitioners by an estimated 72.0% of the population⁸. There is fast-growing usage of Complementary and Alternative Medicine (CAM), both in self-medication and visits to practitioners whose numbers now equal half the General Practitioners in private practice.

Health care expenditure in South Africa was estimated to be R108 billion in 2005, equivalent to 7.7% of the Gross Domestic Product (GDP). This has declined from 8 to 8.5% of GDP throughout the 1990s and early 2000s, largely due to the rapid growth in GDP in recent years. South Africa’s level of spending remains relatively high by international standards; it exceeds that in the majority of countries of a similar level of economic development and is similar to that in some high income countries. Economists therefore argue that the key challenge facing healthcare in South Africa is not lack of resources, but rather the need to use the existing resources more efficiently and equitably.

3. International Developments in Healthcare Financing

A useful way to understand healthcare financing is to use a model advocated by the World Health Organization (WHO) and drawn below for South Africa. Rather than focus on simplistic “public vs. private” debates, these so-called “Kutzin diagrams” enable a more nuanced understanding of healthcare financing and the changes that are envisaged.

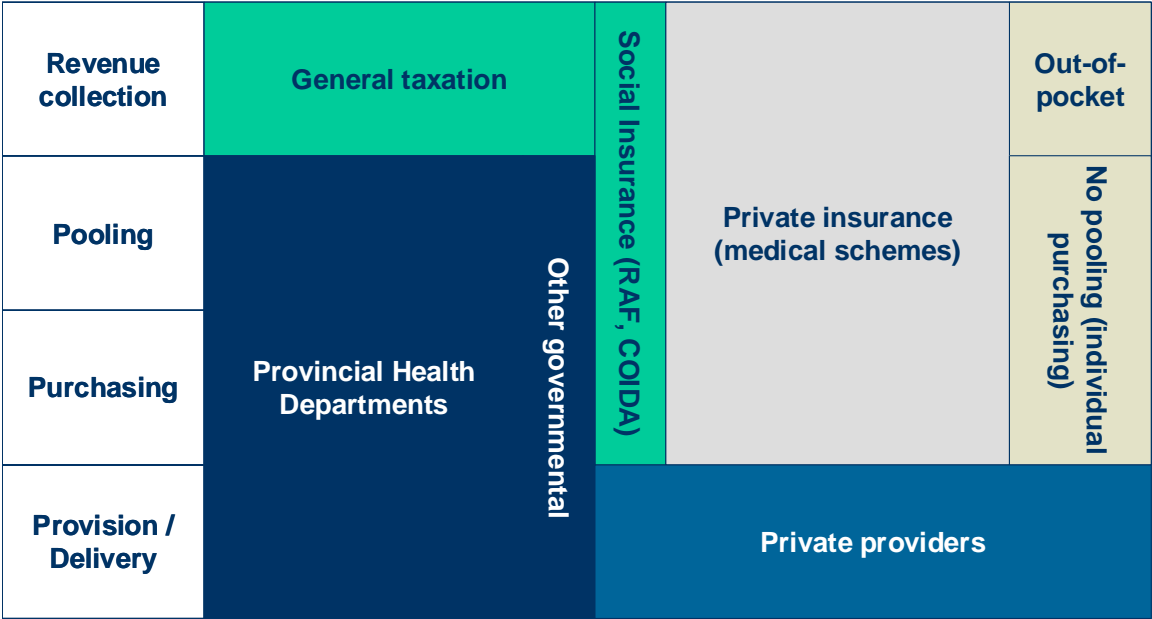


Figure 1: Current Healthcare Financing in South Africa, drawn using value of expenditure⁹
 (Source: Ministerial Task Team on SHI, 2005)

⁸ South African Health Review, 2007, Chapter 12, *Traditional and Complementary Medicine*; and Chapter 13, *Economics of the Traditional Medicine Trade in South Africa*.

⁹ RAF is the Road Accident Fund. COIDA is the fund that provides compensation for occupational injuries and diseases, previously known as “workmen’s compensation”. Both RAF and COIDA are funded by mandatory levies and use private providers to deliver care. Out-of-pocket payments include all amounts paid directly by consumers. There is no pooling on out-of-pocket payments as each consumer or family carries their own risk.

The WHO argues¹⁰ that the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective healthcare. In this way society reduces or eliminates the possibility that an individual will not be liable to pay for such care, or that the family will be impoverished as a result.

There are three related functions in healthcare financing in order to procure delivery:

- **Revenue collection** is the process by which the health system receives money from households, organizations, companies or donors.
- **Pooling** is the accumulation and management of revenues to ensure that the risk of having to pay for healthcare is carried by all the members of the pool and not by each contributor individually. This is the insurance function within the health system¹¹.
- **Purchasing** is the process by which pooled funds are paid to providers in order to ensure ...
- **Delivery** of healthcare to members of the population.

There has been overwhelming evidence from health economists that out-of-pocket payments hurt the poorest and often prevent people getting care. Other ways of getting revenue to a health system are general taxation; mandated social health insurance contributions (usually salary-related and almost never risk-related); voluntary private health insurance contributions (usually risk-related); and donations. Pre-payment is now considered the best form of revenue collection for a health system as it leads to greater fairness.

The world-wide move to pre-funding for healthcare culminated in a resolution by the WHO in May 2005¹² urging member states to ensure that their health financing systems include a method for prepayment of financial contributions for healthcare and to plan the transition to universal coverage of their citizens.

Health economists generally distinguish between National Health and Social Health Insurance 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^{13, 14}. The name adopted for mandatory insurance is a question of local preference and often reflects the values of the society.

¹⁰ The World Health Report 2000: Health systems: Improving performance. Chapter 5: Who pays for health systems? (pp. 95-115).

¹¹ Medical savings accounts work against pooling by individualising expenditure so that it is more like out-of-pocket expenditure.

¹² *Sustainable Health Financing, Universal Coverage and Social Health Insurance*. WHO Resolution at the Fifty-Eighth World Health Assembly.

¹³ Germany has a system known by the abbreviation SHI which means Statutory Health Insurance and which covers the entire population.

¹⁴ Indonesia is implementing a National Health Insurance scheme where only contributors are initially covered and gradual incorporation of other groups is envisaged.

4. A Brief History of National Health Insurance in South Africa

A scheme for a national health service broadly similar to the British model was proposed in South Africa in 1944, comprising free healthcare and a network of community centres and general practitioners as part of a referral system, but was not implemented when the political landscape changed. The *apartheid* years were characterised by an increasing orientation to free market and pure insurance principles for private health insurance.

The African National Congress released a comprehensive plan for healthcare reform in 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.

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.

A particularly useful summary of the findings of each group is by McIntyre and Van den Heever in the South African Health Review of 2007¹⁵. They describe the “considerable discussion and sometimes very heated debates” and outline the core features of each of the proposals on the four functions of the health system.

The future vision for the South African healthcare system was most recently publicly articulated in the Report of the Social Security Committee of Inquiry (the Taylor Committee), released in May 2002. A more detailed discussion document on healthcare was also released by the Department of Health (2002). The four phases of reform of private sector healthcare have an initial goal of a Social Health Insurance system. The reports recommended that South Africa move ultimately towards a National Health Insurance system that integrates the public sector and private medical schemes in a universal contributory system, as interpreted in the three sequential diagrams below.

The current minimum benefits that must be offered by medical schemes to all members are only some 50% of total benefit expenditure. Without expansion of the package, the reform of revenue collection and pooling are only partially possible, as shown in Figure 2. If the minimum package is extended to cover all current expenditure in medical schemes, then revenue collection and pooling are expanded as shown in Figure 3. Out-of-pocket expenditure is reduced in all three diagrams.

¹⁵ South African Health Review, 2007, Chapter 5, *Social or National Health Insurance*.

Revenue collection	General taxation	Other governmental	Social Insurance (payroll tax)	Medical Schemes	Out-of-pocket
Pooling	Provincial Health Departments		Risk Equalisation Fund	Medical Schemes	No pooling (individual purchasing)
Purchasing			Private insurance (medical schemes)		
Provision / Delivery			Private providers (including public hospitals)		

Figure 2: Healthcare Financing in South Africa after Social Health Insurance with current Minimum Benefit package

Revenue collection	General taxation	Other governmental	Social Insurance (payroll tax)	Out-of-pocket
Pooling	Provincial Health Departments		Risk Equalisation Fund	No pooling (individual purchasing)
Purchasing			Private insurance (medical schemes)	
Provision / Delivery			Private providers (including public hospitals)	

Figure 3: Healthcare Financing in South Africa after Social Health Insurance with expanded Minimum Benefit package

At this point, provided all employed people are contributing, there is very little difference in revenue collection to the diagram below. Income tax on employment (PAYE and SITE) will be paid by those same employees while everyone contributes to general taxation via VAT. This can be formalised as revenue collection for health at a national level as shown in the final diagram below.

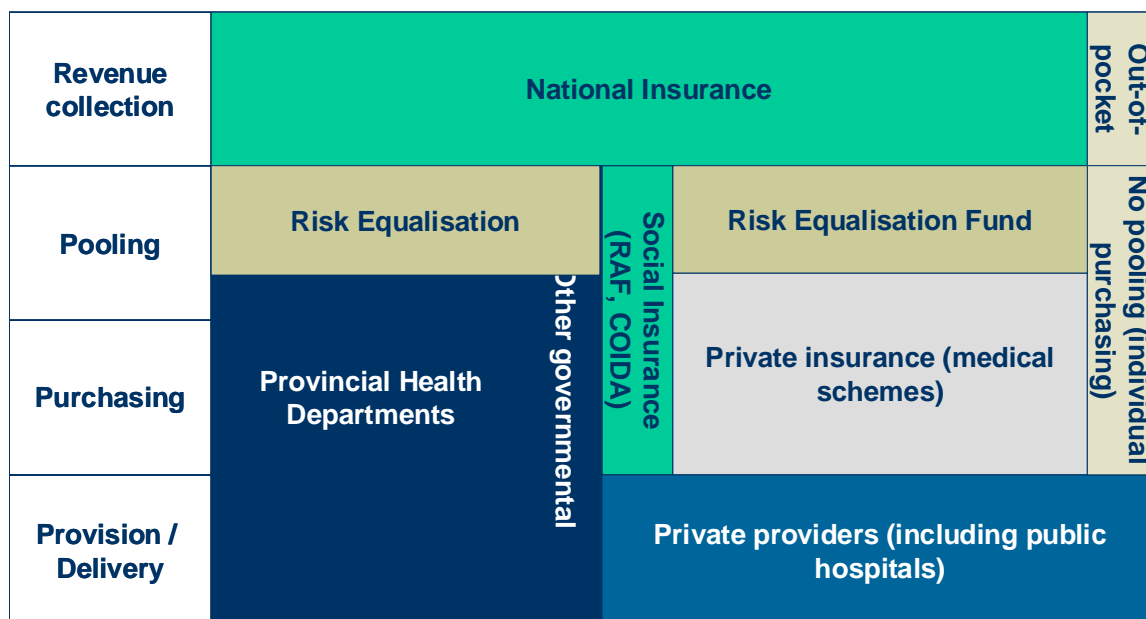


Figure 4: Healthcare Financing in South Africa after National Health Insurance

It is important to note that the focus of the proposed reform in South Africa is on the revenue collection and pooling functions. The reforms do not affect the purchasing and delivery of care in the three diagrams. This dispels one of the myths of National Health Insurance: that it necessarily means “nationalized” healthcare. There may well need to be other reforms to make purchasing and delivery more efficient but these are not discussed here¹⁶.

To the great frustration of academics and those working on the reforms, all subsequent reports since 2004 prepared by the Ministerial Task Team for Implementing SHI and the National Treasury (as part of a joint inter-departmental process) have not been publicly released. This lack of communication and engagement has been to the detriment of the process. Initial reaction to the 2002 proposals by COSATU was to argue for a tax-funded national health system immediately. The findings of work by NALEDI¹⁷ on the affordability of such a proposal were also not publicly released.

In 2008 we have seen a marked shift in Government pronouncements from using “SHI” to speaking of “National Health Insurance” as in section 1. McIntyre and 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.

¹⁶ The Minister of Health has been at loggerheads with the private hospital industry on tariff increases. On 18 April 2008 a draft bill was gazetted creating a central bargaining chamber for setting prices for healthcare for the minimum benefit package.

¹⁷ NALEDI is the National Labour and Economic Development Institute, established by COSATU. Web-site: <http://www.naledi.org.za/>

5. Reform of Medical Schemes for Mandatory Health Insurance

Medical schemes reimburse their members for actual expenditure on health and are governed under the Medical Schemes Act of 1998. The Council for Medical Schemes¹⁸ is the regulator established under this legislation to protect the interests of beneficiaries at all times. Medical schemes are run on a not-for-profit basis and are essentially mutual societies, owned by their members. They are governed by boards of trustees of which 50% must be elected from the members. However in practice the trustees have tended to act on the advice of for-profit healthcare administrators, consultants and managed healthcare organisations.

In 2006 there were 124 medical schemes¹⁹, of which 41 were open schemes (open to any member of the public) and 83 were restricted schemes (restricted to an employer, profession, industry or union). These 124 schemes covered 2.985 million members and their families, making 7.127 million beneficiaries (or “lives” or “belly-buttons”) in total. Scheme trustees direct the design of benefit options, or packages of benefits. In 2006 there were 381 different options across the 124 medical schemes.

One of the myths of mandatory health insurance is that it means only one scheme and that medical schemes as we know them will disappear. Some mandatory systems do have a single central pooler and purchaser but in many of these systems the trend has been to introduce more competition and to have multiple competing pools. The South African reforms, as agreed since 1994, envisage that competing medical schemes are the vehicles through which mandatory health insurance will be delivered.

Reform of medical schemes 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 conditions²⁰ with no limits or co-payments.

¹⁸ A statutory body with the Registrar and board appointed by the Minister of Health. An industry levy is used to provide operating funds for the Council.

¹⁹ Council for Medical Schemes Annual Report 2006/7.

²⁰ The Prescribed Minimum Benefit 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 providers²¹ and formularies²² of medicines. 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 capitation²³ forms of payment.

In January 2004 the Minister of Health stated there were three issues on the unfinished reform agenda toward implementing Social Health Insurance (SHI): risk-related cross-subsidies; income-related cross-subsidies; and mandatory cover for the families of those with incomes above a certain level. These three core principles of a mandatory health insurance system are explored more fully in the next section.

At present, members (sometimes supported by an employer) make direct contributions to medical schemes as shown below in Figure 5. 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).

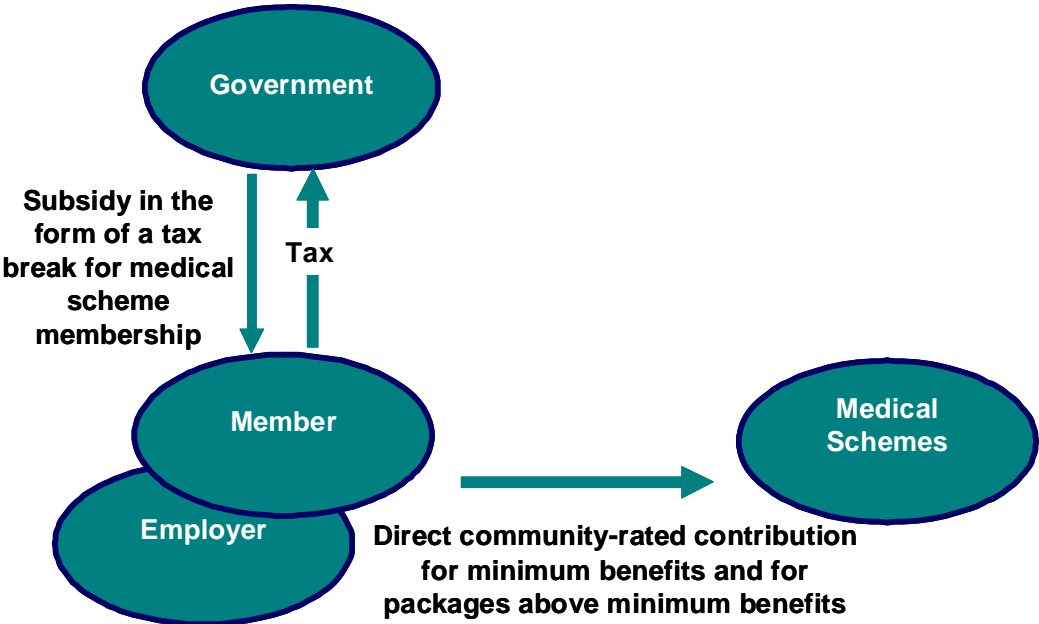


Figure 5: Current Flow of Funds in Voluntary Medical Schemes

²¹ Designated Service Providers or DSPs
²² Lists of cost-effective medicines that the scheme will reimburse.
²³ 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.

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.

6. Preparation for a Mandatory Health Insurance System

There are three further reforms needed to achieve a system of mandatory health insurance:

- 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 internationally²⁴ in having open enrolment, community rating and minimum benefits without risk equalisation at present. 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.

²⁴ 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).

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.

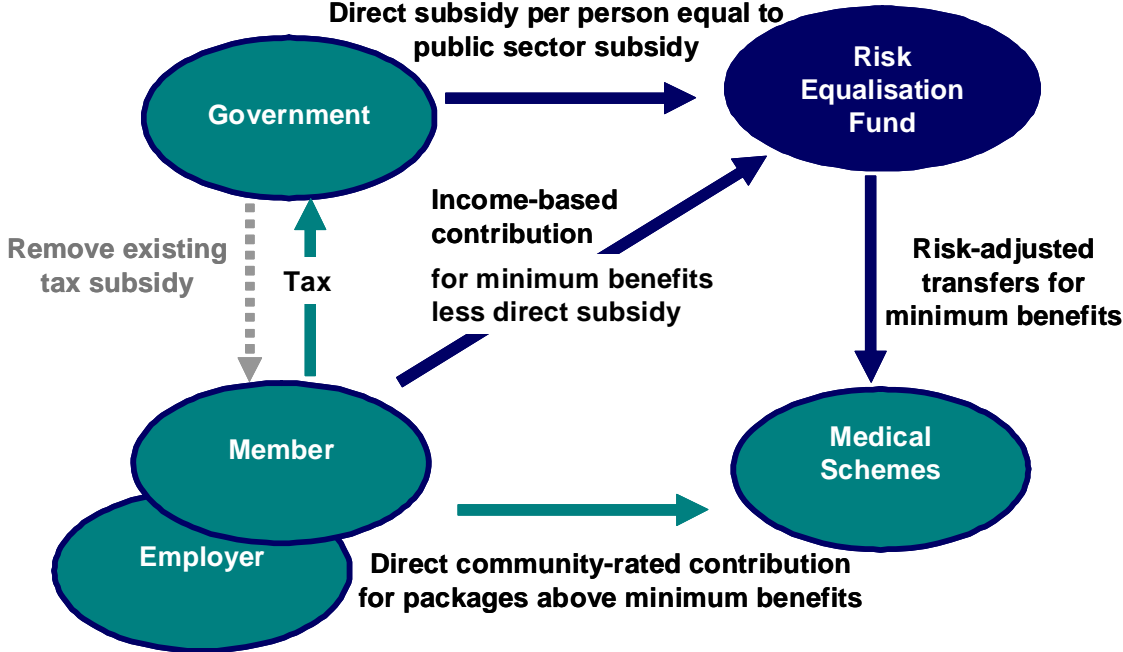


Figure 6: Envisaged Flow of funds under Mandatory Health Insurance

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 recently estimated²⁵ 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. 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.

²⁵ *Framework for Post-Retirement Protection in Respect of Medical Scheme Contributions.* In: Department of Social Development. *Reform of Retirement Provisions, Feasibility Studies.*

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. In 2006²⁶ there were 381 different options across all medical schemes where each option represents a separate risk pool. The Council for Medical Schemes has indicated its intention in Circular 8 of 2006 to drive a process of reform of option and benefit design. In future we can expect fewer options and more standardized benefit packages which would begin to focus competition away from these issues and onto cost-effective delivery of healthcare.

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.

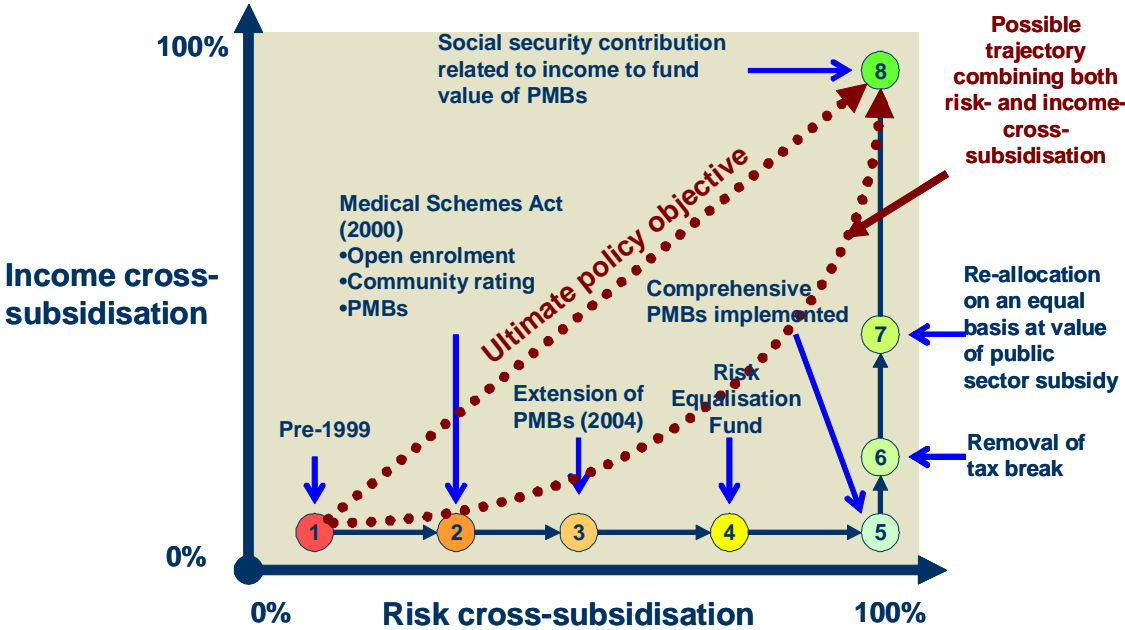


Figure 7: Policy Flow in Medical Schemes to achieve Mandatory Health Insurance
 (Source: Ministerial Task Team on SHI, July 2005, amended)

Substantial progress has already been made on the steps as shown above. Current efforts are clustered around item 4, the establishment of the Risk Equalisation Fund, which is central to mandatory health insurance. 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.

²⁶ Council for Medical Schemes Annual Report 2006/7

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 rate²⁷ determined by REF would need to charge members for the difference on a community-rated basis.

The International Panel²⁸ had argued for urgent implementation of the risk equalisation mechanism and the first date suggested was 2005. 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 draft Bill for an amendment to the Medical Schemes Act of 1998, which would establish the Risk Equalisation Fund, was gazetted in November 2006. Amendments to the bill have again been delayed but the bill is expected in parliament during 2008. Currently the targeted date for the REF implementation from which financial transfers will take place is 2010.

Extensive consultation on the design of the REF and its formula for operation occurred in conjunction with stakeholders and the process was thus initially particularly cooperative and was welcomed by the industry²⁹. Delays in implementation have led to a cooling of sentiment. The delayed implementation has very adverse consequences for schemes with high average age profiles and chronic disease.

There have also been increasing attempts to lobby for exclusion from REF by certain funds on the grounds that as net payors to REF they would be adversely affected. A response by RETAP to the Minister of Health on the draft legislation for REF³⁰ demonstrated that excluding two government schemes with younger members from REF would mean that members of all other schemes would have to pay more. This was argued to be outrageous and unfair. It would amount to an extra tax on all other members of medical schemes to allow these two government schemes to have an exemption from REF. If we all stand together, the price of healthcare reduces for all. This is the essence of solidarity and is a key feature of a mandatory system.

A rapid implementation of REF in 2005 or 2007 would arguably have had a smoother passage than can be expected if the legislation comes to parliament in 2008. As REF is a key organisational component of the envisaged mandatory system, any delays in REF imply concomitant delays in the mandatory system. However once REF is in place, then the pace of implementation of a mandatory system could be very rapid. It would require only changes to government allocations to health and tax reforms implemented at the time of an annual budget. The social security contribution for health and that for retirement could conceivably be implemented simultaneously, again with changes coming from the National Treasury.

²⁷ The REF industry community rate is the average payment per life needed from all medical schemes in order for risk equalisation to be a zero-sum-game.

²⁸ *International Review Panel Report to the South African Risk Equalization Fund Task Group.*

²⁹ South African Health Review, 2007, Chapter 4, *Medical Schemes.*

³⁰ Comments by the Risk Equalisation Technical Advisory Panel on Draft Medical Schemes Amendment Bill 2007. 27 February 2007.

7. Making Healthcare More Affordable: Impact on Workers

The greatest challenge facing medical schemes is to make healthcare more affordable to lower income workers. Despite significant attempts to find solutions for so-called “low income medical schemes” (LIMS)³¹, there has been little practical progress. Government’s lack of positive reaction to the industry’s LIMS proposals has slowed down initiatives in that area. The draft bill in November 2006 had a one-line enabling clause that might allow the Minister to make future regulations for specific low-cost options.

The graph below shows the number of people covered by medical schemes in each income band in 2005. There is a strong pattern by income: for those earning over R10,000 per month, between 75% and 85% are already on medical schemes and roughly the same proportion of people in their households are covered. This falls off very rapidly so that at the tax threshold, only 33% of earners are covered and only 19% of people in their households. The graph also illustrates the very large number of uncovered lives in the area that LIMS options and schemes might have operated (income between R2,000 and R6,000 per month).

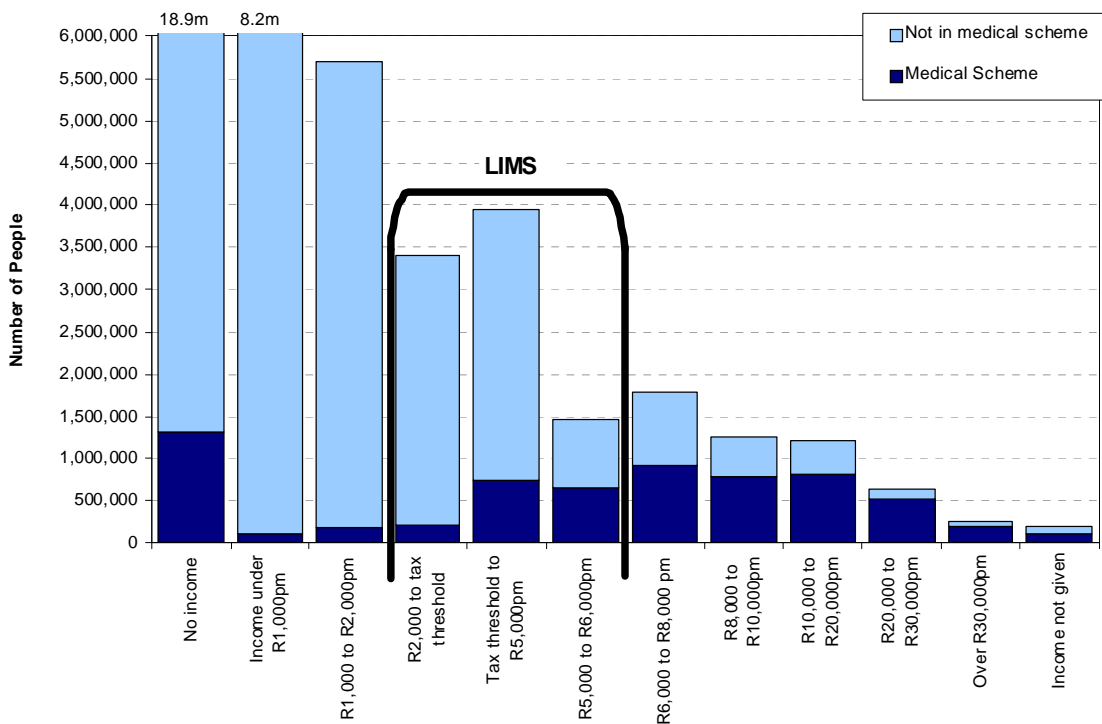


Figure 8: Coverage in Medical Schemes by Income Levels
(Source: Derived from General Household Survey 2005, StatsSA)

One of the ways lower income earners have coped with the high price of medical cover and high contribution increases is to leave their children off the scheme. This means that the industry as a whole has fewer young people than would be expected and this raises the average price of health cover. It has been estimated that there are some 1.3 million people in households without cover where someone in the household is already on a medical scheme.

³¹ *Consultative Investigation into Low Income Medical Schemes, 2006.*

The effects of low income on access can be off-set if there is a significant employer subsidy for healthcare. In the absence of a mandated social security system for healthcare, there is a range of positions an employer can choose to adopt with regard to funding healthcare. These range from “seeing healthcare as an aggravating and potentially ruinous cost of doing business” to being “an investment in business success” where “healthy people deliver healthy profits”. Companies that choose the former position might meet legislated occupational health standards, to provide a fixed subsidy for healthcare to all workers and allow for contributions to be collected from the payroll, but not involve themselves further in healthcare issues. Companies that choose the latter position seek to invest in employee healthcare in order to improve worker performance and satisfaction. They might become active purchasers of healthcare and seek to integrate all company health-related initiatives, as most frequently seen by the mining houses and major retailers. These companies also often incorporate more of a focus on wellness and prevention rather than only providing curative care.

One of the few success stories on affordability in recent years has been the development of GEMS, the Government Employees Medical Scheme. During the 1990s public sector workers were allocated an employer subsidy for medical schemes and could use this to join any open medical scheme of their choice. The 1999 Remuneration Policy Review in the public sector had identified major shortcomings, including inequality in access to medical scheme cover, affordability concerns, lack of value for money, spending inefficiencies and little integration with public sector health care. Despite a relatively generous medical scheme subsidy, there were only some 450 000 people, half of the one million employees, using the subsidy.

In 2002, Cabinet approved a framework policy for a restricted medical scheme, only for public sector employees. GEMS became operational in January 2006. Government has used the lure of a higher medical scheme subsidy within GEMS, as well as insisting that all new employees may only join GEMS. It was reported in November 2007 that GEMS had reached 190,000 principal members or some 500 000 lives, making it the largest restricted scheme and the third largest medical scheme in South Africa. GEMS has recently been growing by between 30,000 and 40,000 lives a month with some being members and others being members moving from open schemes.

The combination of high subsidies for low income workers and income-related contribution tables of the new GEMS scheme have been significant. A low-wage earning civil servant and family is able to join the lowest cost option, Sapphire, without making an out-of-pocket contribution. It is estimated that the Sapphire option alone could bring about 600 000 new lives into the medical scheme market and that GEMS may ultimately see the enrolment of an additional 1 million medical scheme beneficiaries (an increase of some 14% from current industry levels).

A myth about GEMS is that this is (or will become) the National Health Insurance Scheme. This is sheer nonsense. GEMS is simply a very large employer choosing to have a restricted medical scheme for its own employees. There is a link though to policies for a mandatory health insurance scheme in that the Taylor Committee argued that Government could not mandate other employers to provide health cover for all their workers if it was not seen to be doing the same for public sector workers. GEMS is important then as a role model for how employers could make healthcare more affordable and provide cover to all employees.

It is envisaged that the mandatory health insurance reforms would increase the number of beneficiaries in medical schemes from 7 million to at least 14 million. If contributions are made by all employed, including those earning below the tax threshold, the number covered could increase to some 22 million or 47% of the total population. In future, as the economy grows, so more people might become eligible to participate and thus further expand the pool of covered lives.

Mandatory membership has an important effect on reducing the price of healthcare for everyone³². In a voluntary environment people can move onto medical schemes when they believe they might need cover, despite the existence of waiting periods and late-joiner penalties. If all people in households where someone is earning above the tax threshold were covered in medical schemes, then the price of minimum benefits would fall to 93.2% of the voluntary market level.

There is evidence that more women of child-bearing years have entered medical schemes than would be expected in a mandatory system and thus a large proportion of maternity costs are probably already being covered in medical schemes. There is evidence in the REF data and the LIMS process that those with chronic disease are already more likely to be on medical schemes. Taking into account these effects, the price of minimum benefits could decrease to 78.3% of the voluntary levels. Another way to look at this phenomenon is that prices of minimum benefits in the voluntary environment are some 20 to 30% more expensive than they could be at various stages of mandatory cover.

A mandatory health insurance system will have a very large effect on affordability of healthcare for low income workers through the change in Government subsidy and the introduction of income cross-subsidies. At present, a low income worker with a family of four might need nearly 40% of income to be spent on medical cover and can only afford this if the employer subsidy is generous. Simply removing the tax break for high income earners and replacing it with a per capita subsidy (a fixed amount per person per month) would reduce the cost for lower income workers to some 20% of income³³.

If an income cross-subsidy is introduced to pay for the balance of the minimum benefit package, as envisaged in section 6, then the cost for the lower income workers falls to about 8% of income. The cost for higher income earners goes from some 3% to 5% of income under the cross-subsidy as envisaged. However the extent of the income cross-subsidy is an area that has not been debated in the industry or discussed with the social partners.

In summary, mandatory health insurance should be a very positive development for workers and particularly for low income workers:

- Competitive medical schemes mandated to provide minimum benefits which will be paid by contributions related to income.
- Price of minimum benefits will fall as younger lives become part of the mandatory system. If NHI implemented from income of R1,000 pm, then cost of PMBs falls to 78 % of current level.

³² *Framework for Post-Retirement Protection in Respect of Medical Scheme Contributions*. In: Department of Social Development. *Reform of Retirement Provisions, Feasibility Studies*.

³³ Analysis contained in document prepared by the Ministerial Task Team on SHI in July 2005 but not publicly released.

- Covered lives to increase from **7.4 million** to at least **15 million** and possibly higher – current ceiling of **22 million** (depends on income level for mandatory membership and degree of income cross-subsidy).
- Competition between schemes changes away from trying to attract young and healthy. Increased focus on cost of delivery of healthcare and cost-effectiveness of treatment.
- Affordability could improve substantially for lower income workers and their families. Extent of income cross-subsidies still uncertain.

8. Issues for Debate

That reform needs to happen in healthcare financing in South Africa is not at issue. The ANC has been committed to these reforms since 1994, as confirmed at all subsequent policy conferences. Government ministers have repeatedly announced a commitment to the reforms. The healthcare industry also accepts that reform of the current system of voluntary insurance is critical. However there are still details of parts of the reform that have not been fully worked through or publicly debated. Whether there will be a formal debate at NEDLAC is of course a key issue.

This document has focused largely on Government's view of the reforms. We know something about employers views from a survey conducted in 2005³⁴. The latest publicly available material from organised labour is the COSATU/ NEHAWU submission in June 2003 to the Taylor Committee.³⁵

More recent labour pronouncements would seem to suggest that there could be three major fault-lines between the social partners. The first is likely to be on the question of a single system vs. a public system in parallel with a social security system for those who can afford to contribute. A related issue is whether to have an entirely tax-funded system vs. payment by means of income-based contributions. The third fault line might be on the question of a single-payer system vs. the multiple competitive pool structure described in this document.

Covering everyone or covering those who can afford to contribute

The Taylor Committee report makes it clear that the overall objective for South Africa is to establish a system of national health insurance that covers all citizens. However some phasing to reach this objective is necessary. The report³⁶ says "Initially the environment would remain differentiated between a private contributory environment and a general tax funded public sector environment. Over time this strict differentiation should diminish with a broader contributory environment emerging, replacing general taxes as a revenue source. The ultimate elimination of general taxes as a key revenue source is unlikely for a fairly long time."

³⁴ Old Mutual 2005 Healthcare Survey: towards Social Health Insurance.

³⁵ COSATU/NEHAWU Submission to the Public Hearings on the Report of the Committee of Enquiry into Comprehensive Social Security System.

³⁶ *Transforming the Present – Protecting the Future*, Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa, May 2002, page 86.

The major reason for not pushing ahead immediately to a national system where some contribute and all get the same benefits is the cost. Initial estimates of the social security contribution required for health were of the order of 3.5% to 4% if only contributors were covered. Using the same contributors to extend coverage at the same level to the entire population might cost of the order of 15% of income. This is clearly unaffordable.

South Africa has a very young population: 61.5% are under age 30 and only 5.0% are over age 65. This is useful in developing a social security system as the burden of the elderly on any such system is not nearly as heavy as in Europe, North America and Japan. However using the General Household Survey of 2005 from StatsSA, the following impediments to an immediate full national health system were found:

- Total population of 46.9 million people in 2005, of whom 20.1 million (42.8%) were children under the age of 20. There are 28.9 million (61.6%) under the age of 30.
- Nearly 90% of this large young group under age 30 is not yet employed and hence not yet able to contribute to a mandatory system.
- Only 22.4% of all individuals in the country report having any income.
- Only 8.2% of individuals report having income above the tax threshold.
- 54.0% of the working age population do not earn any income.
- 40.3% of the population live in a household where there is no-one who earns an income.
- 19.5% of individuals in the country receive a Social Security grant of some form. SOAP³⁷, Disability and Child Support are major grants.
- 54.0% of people are in households receiving a Social Security grant. SOAP and Child Support have a major effect on households.

The WHO has a useful document³⁸ that describes the length of time it has taken in some other countries to move from the first legislation on social health to full coverage of all citizens. Some examples are:

- **Germany:** 1854 to 1988 (127 years)
- **Belgium:** 1851 to 1969 (118 years)
- **Israel:** 1911 to 1995 (84 years)
- **Austria:** 1888 to 1967 (79 years)
- **Luxembourg:** 1901 to 1973 (72 years)
- **Costa Rica:** 1941 to 1961 but only 83.4% coverage by 1991.

Only two countries achieved full coverage in under 40 years:

- **Japan:** 1922 to 1958 (36 years)
- **Republic of Korea:** 1963 to 1989 (26 years)

The important thing for South Africa is to **start** a process of mandatory health insurance. We may not be able to cover everyone immediately but the intention is to do so as soon as employment and incomes make this feasible.

³⁷ SOAP is the Social Old Age Pension that is provided on a means-tested basis to women over the age of 60 and men over age 65. The pension age is planned to equalise at age 60 by 2010. The amount of the grant is R940 per month from 1 April 2008.

³⁸ *Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period.* WHO, 2004.

Tax-funding vs. Social Security Contributions

A useful resource on the experience of tax-funding of health systems is Savedoff's paper for the WHO³⁹. Savedoff says "Many issues in raising funds for health care through tax-based systems are not specific to the health sector; rather, they are shared with other public services financed out of revenues. In this regard, several questions generally arise: Should we tax income or consumption? Should we rely on national or local taxes? And should we rely on general or earmarked⁴⁰ taxes? In practice, countries have answered these questions many different ways."

Savedoff concludes: "Choosing to finance a health system out of government revenues is not something that happens without precedent. ... Despite theoretical debates over the merits of consumption versus income taxes, national versus local, and earmarked versus general, the best guidance for tax policy is to focus on very pragmatic questions. Taxes should be raised keeping in mind the costs of tax administration, tax distortions in economy, and the politics of allocations (in the case of set-asides and earmarking). The net equity of health system financing depends more on the amount of funds that the tax system mobilizes and the way in which it is spent, than on the progressivity or regressivity of the taxes themselves."

McIntyre and Van den Heever⁴¹, in assessing the proposals for mandatory insurance in South Africa, find that "all of the proposals recognise that it will be necessary to secure mandatory health insurance contributions (or have a dedicated payroll tax for health care), which should be shared between employees and employers, as well as general tax resources. There was also general agreement across the proposals that those who could contribute to covering the costs of health care (over and above normal tax payments) should do so."

The COSATU view in 2003⁴² was that a tax-funded system would be preferable: "Key in the recommendations of Taylor is to change the current environment of a general tax funded public sector and a private contributory environment to a broader contributory environment, replacing taxes as a source of revenue. We believe that this model ... is unrealistic. This also raised the question, do we want the state to relinquish funding in the long run, and what are the political consequences for this to happen. It is our belief that a universal contributory system is not the appropriate model for our country."

Overall Design of Collection, Pooling and Purchasing

There are many ways to design collection and pooling. For example⁴³, "social health insurance contributions may be collected by individual funds (as in Germany), an association of funds (as in Luxembourg), a central fund (as in the Netherlands) or local branches (as in France). There may be a single national fund for all eligible persons or multiple funds. Membership may be assigned either according to occupation and/or region (as in Austria) or the population may have a free choice of fund (as in Belgium, Czech Republic, Germany and the Netherlands). Where funds compete there is usually a mechanism to ensure risk pooling

³⁹ *Tax-Based Financing for Health Systems: Options and Experiences.*, p4 and p17.

⁴⁰ A tax may be earmarked (or hypothecated) for a specific purpose such as health care.

⁴¹ South African Health Review, 2007, Chapter 5, *Social or National Health Insurance*, p81

⁴² COSATU/NEHAWU Submission to the Public Hearings on the Report of the Committee of Enquiry into Comprehensive Social Security System, section 5.

⁴³ Policy brief on *Funding health care: options for Europe*, p3.

between funds, either through the central allocation of funding (as in the Netherlands) or reallocation between funds (as in Germany).”

There are numerous examples of countries with single pool systems now attempting to introduce more competition, particularly in Europe. Van der Ven and colleagues describe the rationale for a multiple pool system⁴⁴: “From the mid-1990s citizens in Belgium, Germany, Israel, the Netherlands and Switzerland have a guaranteed periodic choice among risk-bearing sickness funds, which are responsible for purchasing their care or providing them with medical care. The rationale of this arrangement is to stimulate the sickness funds to improve efficiency in health care production and to respond to consumers’ preferences.”

COSATU in 2003 argued for a single pool and single funder: “We propose the NHI to end the two-tier system by incorporating all health resources into the public sector. A new NHI Authority would allocate the health budget to hospitals and practitioners. It would be funded by the existing budget plus a progressive dedicated levy equal to existing private health costs.”

Definitions of Contributors and Families Covered

National Treasury and the Department of Social Development seem determined to press ahead with retirement reform as rapidly as possible. It would be preferable for health reform and retirement reform to proceed together and to use the same definitions. Examples of key definitions that still require clarity in social security reform are as follows:

- Whether residence or citizenship will determine eligibility to contribute;
- The inclusion of domestic workers and farm workers as contributors;
- The inclusion of temporary, part-time and seasonal workers;
- The inclusion of the self-employed;
- The definition of ‘family’ for health cover and survivor benefits;
- The definition of income that will be used to determine eligible income for calculating contributions.
- The income above which a person will contribute to social security.

Definition and Design of Income Cross-Subsidies

In section 1 Minister Skweyiya is quoted as saying we will build on a “value system based on human **solidarity**”. In social systems of insurance, **solidarity** means de-linking contributions from individual risk and instead making them equal (as under community rating) or linking them to the ability to pay (as in income cross-subsidies). Solidarity, when fully implemented, requires that contributions are **mandatory** for all above a certain income.

However while many of the actors use the terminology “solidarity” freely, there has been little work done on exactly what this might mean. The definition of contributions is affected by the imposition of floors, caps and measures designed to restrict the amount the highest income earners might pay.

⁴⁴ Van de Ven WPMM, et al., Risk adjustment and risk selection in Europe: 6 years later, Health Policy (2007), doi:10.1016/j.healthpol.2006.12.004.

The table below was produced for a feasibility report on funding post-retirement medical contributions as part of a mandatory health insurance system⁴⁵. The base costing without post-retirement funding was found to range between 3.0% and 3.8% of income. The inclusion of cover for all retired people increased this range to 3.1% to 3.9%, depending on the scenario for coverage. Two of the many possible definitions for limiting contributions were then explored: Definition A was calculated on income above a threshold while definition B has a cap for high income earners similar to that initially envisaged by National Treasury.

Table 2: Impact of definition of Contribution on Social Security Contribution for Healthcare (2005 Rand terms)

		Scenario 1	Scenario 2	Scenario 3
		Contributors are those earning above the tax threshold.	Contributors are those earning above R2,000 pm.	Contributors are those earning above R1,000 pm.
Base Costing in this Report	Number of Contributors	4,781,470	6,040,447	7,950,348
	Total Monthly Income	33,087,509,704	35,880,434,412	38,461,495,087
	Monthly Contributions at 1% of all income from the first Rand	330,875,097	358,804,344	384,614,951
	Social Security Contribution using definition above	3.1%	3.4%	3.9%
Other possible definitions of Contributions	A: Monthly Contributions at 1% of income above threshold for contribution	283,060,402	298,399,871	305,111,467
	Social Security Contribution using definition above	3.6%	4.1%	5.0%
	B: Monthly Contributions at 1% of all income with maximum equivalent to R750 at 15% contributions	204,038,236	231,967,483	257,778,090
	Social Security Contribution using definition above	5.0%	5.2%	5.9%

Definition A in the table above favours low-income contributors, as contributions rise more slowly from the threshold for contribution. Definition B favours high-income contributors, as the cap on total contributions in Rand terms cuts the size of their contributions. Definition B however, results in the percentage of income increasing substantially to a range of 5% to 5.9% of income.

Different definitions of contributions produce different levels of contribution which have an impact on the perception of affordability. More importantly, the different definitions also have equity implications. Whatever the social partners agree, it is certainly preferable to have mandatory contributions for health and for retirement funding use the same income threshold, contributor definitions and methods for determining contributions.

McIntyre and Van den Heever⁴⁶ found that “a key remaining area of debate is the extent to which contributions should be income related. The two options are:

- A proportional structure, where each contributor pays the same percentage (e.g. 5%) of their salary; or

⁴⁵ *Framework for Post-Retirement Protection in Respect of Medical Scheme Contributions*. In: Department of Social Development. *Reform of Retirement Provisions, Feasibility Studies*, page 63.

⁴⁶ South African Health Review, 2007, Chapter 5, *Social or National Health Insurance*, p81

- A progressive structure, where those with a higher salary pay a higher percentage of their salary (e.g. 6%) than those with lower salaries (e.g. 4%).”

It would also be possible to structure the income-related contribution to follow the same progression as the tax system. This issue is a critical one and one on which there has been no public participation to date.

The Need for Exposure of the Issues

Healthcare reform has been proceeding since 1994, but reforms to achieve a mandatory health insurance system are proceeding slowly. Although the key institutional component for a mandatory system, the Risk Equalisation Fund, is shortly to receive attention in parliament, the most important reforms will be those that involve income cross-subsidies and mandatory contributions. There has been little agreement within Government on this next phase of healthcare reform and whether it should proceed at the same time as retirement reform.

Neither organised employers nor organised labour have previously fully engaged with the proposed health reforms. The wider public has had almost no exposure to this debate and to material on how the implementation of a National Health Insurance system might affect them personally.

Disclaimer

The views expressed in this document, while drawn as far as possible from published material, are my own. The material here is not the official National Health Insurance system and for those details we must wait for legislation from the Department of Health. To my knowledge that last document in the public domain is 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 equalisation⁴⁷.

⁴⁷ Department of Health (2003) Opening Address to the *Consultative Forum On Risk Equalisation* by Dr Ayanda Ntsaluba, Director-General, Department of Health. Midrand, 10 July 2003.

Appendix A: References and Useful Documents

International Documents

World Health Organization (2000). *The World Health Report 2000: Health systems: Improving performance* Geneva: World Health Organisation.

URL: <http://www.who.int/whr/2000/en/index.html>

World Health Organization (2004) *Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period*. WHO Health Financing Policy Issue Paper, produced by: Department of Health Systems Financing and Resource Allocation WHO/EIP, January 2004. Available on <http://www.who.int>

World Health Organization (2005) *Sustainable Health Financing, Universal Coverage and Social Health Insurance. Resolution*. Fifty-Eighth World Health Assembly WHA58.33, Agenda item 13.16, 25 May 2005. Available on <http://www.who.int>

Mossialos E., Dixon A., Figueras J., Kutzin J. (2002) *Funding health care: options for Europe*. European Observatory on Healthcare Systems, Policy brief No. 4 2002. Available on <http://www.euro.who.int/observatory>

Savedoff W. (2004) *Tax-Based Financing for Health Systems: Options and Experiences*. Discussion Paper Number 4 – 2004. World Health Organization, Department of Health System Financing, Expenditure and Resource Allocation, Geneva. Available on <http://www.who.int>

South African Social Security Reform

Department of Social Development (2002) *Transforming the Present – Protecting the Future*, Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa, March 2002.

URL: http://www.dsd.gov.za/docs_guidelines/2002/2002.asp

National Treasury and Department of Social Development (2007) *Outline of a Social Security and Retirement Savings Framework*: discussion document for the Inter-Departmental Task Team on Social Security and Retirement Reform. 29 November 2007.

URL: <http://www.treasury.gov.za/publications/other/ssrr/default.aspx>

McLeod H. (2007) *Framework for Post-Retirement Protection in Respect of Medical Scheme Contributions*. In: Department of Social Development. *Reform of Retirement Provisions, Feasibility Studies*. 2007. URL: <http://www.dsd.gov.za/>

Social Security Retirement Reform Workshop held on 13 December 2007. Papers from the Inter-Ministerial Task Team and from stakeholders are available in several topic areas. Historic documents from reform process also available.

URL: <http://www.treasury.gov.za/publications/other/ssrr/default.aspx>

Skweyiya Z. (2008) Debate on State of the Nation Address. Address by the Minister of Social Development, Dr Zola Skweyiya on the occasion of the debate on the President's State of the Nation Address, Parliament, Cape Town.

URL: http://www.polity.org.za/article.php?a_id=126693

South African Healthcare Reform

African National Congress (1994) *A National Health Plan for South Africa*. Johannesburg, 1994. URL: <http://www.anc.org.za>

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.

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. 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 Equalisation Fund Task Group*. 16 February 2004.

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

Broomberg J., editor (2006) *Consultative Investigation into Low Income Medical Schemes*. Final Report. 7 April 2006.

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

Medical Schemes in South Africa

Council for Medical Schemes (2007) *Report of the Registrar of Medical Schemes, 2006/2007*. URL: <http://www.medicalschemes.com>

Harrison S., Bhana R., Ntuli A., editors (2007) *South African Health Review 2007*. Durban: Health Systems Trust, 2007.

URL: <http://www.hst.org.za/publications/711>

Public, Employer and Labour Views of Reform

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. *South African Medical Journal*, Vol. 96, No. 9, September 2006.

Old Mutual (2005) *Old Mutual 2005 Healthcare Survey: towards Social Health Insurance*. Available on <http://www.oldmutual.co.za>

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>