

# Understanding Healthcare Financing

*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.*

The debate about the reform from the existing health system to a system of National Health Insurance is essentially a debate about the reform of healthcare financing in South Africa. This background brief provides resources for understanding the components of healthcare financing: revenue collection, pooling and purchasing. International developments are covered and resources provided to understand how reforms are being considered all over the world. Information on the current situation in South Africa is given.

## 1. Introduction to Healthcare Financing

The World Health Organization (WHO) produces an annual World Health Report focussing on a particular health subject in each report. <http://www.who.int/whr/en/index.html>

The World Health Report for 2000 was entitled "Health Systems: improving performance". In the foreword, the Director-General of the WHO, Gro Harlem Brundtland, wrote: "What makes for a good health system? What makes a health system fair? And how do we know whether a health system is performing as well as it could? These questions are the subject of public debate in most countries around the world."

"When I became Director-General in 1998, one of my prime concerns was that health systems development should become increasingly central to the work of WHO. I also took the view that while our work in this area must be consistent with the values of health for all, our recommendations should be based on evidence rather than ideology. .... I hope [this report] will be seen as a landmark publication in the field of health systems development."

World Health Organization (2000). The World Health Report 2000: Health Systems: improving performance (pp. 206) Geneva. URL: <http://www.who.int/whr/2000/en/index.html>

A particularly useful introduction to healthcare financing is Chapter 5: "Who Pays for Health Systems?" [http://www.who.int/whr/2000/en/whr00\\_ch5\\_en.pdf](http://www.who.int/whr/2000/en/whr00_ch5_en.pdf) This chapter introduces a description of health systems that is much richer and more nuanced than simply thinking of public or private systems.

"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 public health and personal health care. This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so.

"To ensure that individuals have access to health services, three interrelated functions of health system financing are crucial: revenue collection, pooling of resources, and purchasing of interventions."

**“Revenue collection** is the process by which the health system receives money from households and organizations or companies, as well as from donors. ... Health systems have various ways of collecting revenue, such as general taxation, mandated social health insurance contributions (usually salary-related and almost never risk-related), voluntary private health insurance contributions (usually risk-related), out-of-pocket payment and donations.”

**“Pooling** is the accumulation and management of revenues in such a way as to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Pooling is traditionally known as the “insurance function” within the health system ...”

**“Purchasing** is the process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions. Purchasing can be performed passively or strategically. **Passive purchasing** implies following a predetermined budget or simply paying bills when presented. **Strategic purchasing** involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom. .... [this is done by means of] selective contracting and incentive schemes. Purchasing uses different instruments for paying providers, including budgeting.”

Many researchers would include **delivery** or **provision of services** as a fourth element when describing a health system. This is taken from the original work by Kutzin which was adopted in the WHO report. Descriptions of health systems using this approach are called “Kutzin frameworks”.

Kutzin, J. (2001). A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*, 56(3), 171-204. URL: [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=11399345](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=11399345)

Kutzin wrote: “Health financing policies are marked by confusion between policy tools and policy objectives, especially in low and middle income countries. This paper attempts to address this problem by providing a conceptual framework that is driven by the normative objective of enhancing the ‘insurance function’ (access to needed care without financial impoverishment) of health care systems. The framework is proposed as a tool for descriptive analysis of the key functions, policies, and interactions within an existing health care system, and equally as a tool to assist the identification and preliminary assessment of policy options.

“The aim is to help to clarify the policy levers that are available to enhance the insurance function for the population as efficiently as possible, given the ‘starting point’ of a country’s existing institutional and organizational arrangements. Analysis of health care financing systems using this framework highlights the interactions of various policies and the need for a coherent package of coordinated reforms, rather than a focus on particular organizational forms of ‘health insurance’. The content of each main health care system function (revenue collection, pooling of funds, purchasing of services, provision of services) and the market structure with which the implementation of each is organized are found to be particularly important, as are policies with respect to the benefit package and user fees.”

Chapter 5 of the World Health report 2000 [http://www.who.int/whr/2000/en/whr00\\_ch5\\_en.pdf](http://www.who.int/whr/2000/en/whr00_ch5_en.pdf) has Kutzin framework diagrams for the United Kingdom, Chile, Egypt and Bangladesh (see page 102).

## 2. WHO Policy and Guidance on Healthcare Financing

The World Health Organization in the World Health Report 2000 describes recent trends: “In the past decade or so there has been a gradual shift of vision towards what WHO calls the ‘new universalism’. Rather than all possible care for everyone, or only the simplest and most basic care for the poor, this means delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability. It implies explicit choice of priorities among interventions, respecting the ethical principle that it may be necessary and efficient to ration services, but that it is inadmissible to exclude whole groups of the population.”

The Secretariat Report to the Fifty-eighth World Health Assembly defines the goal of coverage:

[http://www.who.int/health\\_financing/documents/cov-wharesolution5833/en/index.html](http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html)

**“Universal coverage** is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care.”

The World Health Assembly in 2005 adopted **Resolution 58.33** on **“Sustainable health financing, universal coverage and social health insurance”**

[http://www.who.int/health\\_financing/documents/cov-wharesolution5833/en/index.html](http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html)

The WHO “URGES Member States:

(1) to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;

(2) to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package;

(3) to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;

(4) to plan the transition to **universal coverage** of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;

(5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country;

(6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;

(7) to share experiences on different methods of health financing, including the development of social health-insurance schemes, and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system;

The Secretariat Report to the Fifty-eighth World Health Assembly describes **strategies to achieve universal coverage**:

“Several options for establishing universal coverage exist, which can be classified into two broad strategies. The first is use of general tax revenue as the main source of finance for risk pooling, a system also referred to as tax-funded health financing. The second is introduction of social health insurance, used here to describe the situation where specific contributions for health are collected from workers, self-employed people, enterprises and the government, and are pooled into a single, or multiple, “social health insurance fund”.

“In the first option, all citizens (and sometimes residents) are typically entitled to services, so coverage is automatically universal. With social health insurance, entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population. Universality will be

achieved only if contributions are made on behalf of each member of the population. For this reason most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay themselves. Social health insurance may be managed in various ways, including through a single government insurance fund or through multiple nongovernmental or parastatal funds.

“Ultimately, a country’s decision on how to modify its health-financing system should be guided by decisions on collection, pooling, and purchasing, and the associated organizational arrangements that are most likely to lead to universal coverage in the context of that particular country, taking account of its society’s values and collective objectives.”

There is a wealth of material on the WHO site on Health Financing Policy.

[http://www.who.int/health\\_financing/en/](http://www.who.int/health_financing/en/)

There is a very useful collection of papers on healthcare financing at

[http://www.who.int/health\\_financing/documents/list/en/index2.html](http://www.who.int/health_financing/documents/list/en/index2.html)

### 3. Current Healthcare Financing in South Africa

Health Systems Trust produces an annual report about the state of healthcare in South Africa, with each issue devoted to a particular theme. <http://www.hst.org.za/generic/29>

The South African Health Review 2007 was devoted entirely to private healthcare and its role in the South African health system. <http://www.hst.org.za/publications/711>

The following chapters are particularly useful to understand the current status of healthcare financing in South Africa:

- Harrison, S., Bhana, R., & Ntuli, A. (2007). The Role of the Private Sector within the South African Health System. 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/editorial\\_07.pdf](http://www.hst.org.za/uploads/files/editorial_07.pdf)
- McIntyre, D., & Thiede, M. (2007). Health Care Financing and Expenditure. 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/chap3\\_07.pdf](http://www.hst.org.za/uploads/files/chap3_07.pdf)  
(See particularly diagram on page 37)
- Adams, S., Morar, R., & Jeebhay, M. (2007). Health and Healthcare in the Workplace. 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/chap7\\_07.pdf](http://www.hst.org.za/uploads/files/chap7_07.pdf)
- McLeod, H., & Ramjee, S. (2007). Medical Schemes. 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/chap4\\_07.pdf](http://www.hst.org.za/uploads/files/chap4_07.pdf)
- Mander, M., Ntuli, L., Diederichs, N., & Mavundla, K. (2007). Economics of the Traditional Medicine Trade in South Africa. 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/chap13\\_07.pdf](http://www.hst.org.za/uploads/files/chap13_07.pdf)

Using the material from the SAHR 2007 and particularly the chapters authored by Prof Di McIntyre, the unequal use and distribution of resources (both people and money) in healthcare in South Africa

is summarised below. This is an extract from "Introduction to National Health Insurance" prepared for IMSA in May 2008. [this can be downloaded from the IMSA web-site]

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.

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 specialised. It is estimated by McIntyre 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]

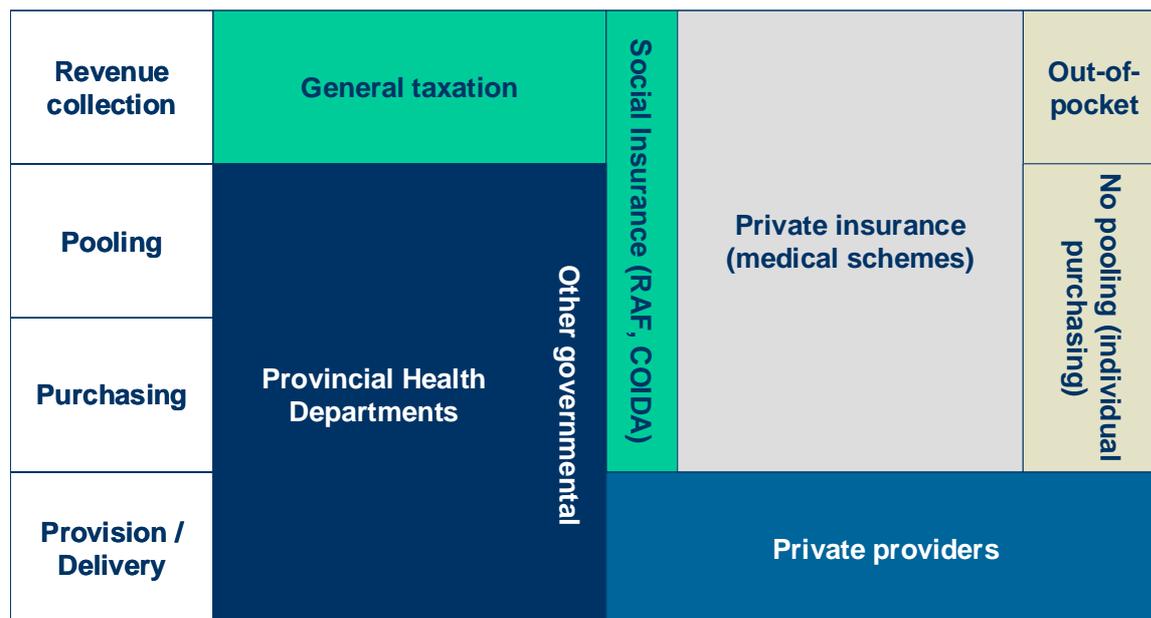
|   | <b>Private Health Insurance</b>            | <b>Some Private + Public</b>              | <b>Public Sector</b>                     |
|---|--|---|--|
| Delivery of healthcare                              | Private primary care and private hospitals | Private primary care and public hospitals | Public primary care and public hospitals |
| Population covered                                  | 7.0 million                                | 9.8 million                               | 30.2 million                             |
| <b>Proportion of population</b>                     | <b>14.8%</b>                               | <b>21.0%</b>                              | <b>64.2%</b>                             |
| Per capita expenditure per beneficiary per annum    | R9,500                                     | R1,500                                    | R1,300                                   |
| <b>Proportion of total expenditure</b>              | <b>55.0%</b>                               | <b>12.3%</b>                              | <b>32.7%</b>                             |
| 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

A seldom-reported part of the health system is the use of Traditional Medicine (TM) practitioners by an estimated 72.0% of the population. 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.

The diagram below illustrates the current financing of healthcare in South Africa using the Kutzin framework. The diagram is adapted from material by the Ministerial Task Team on Social Health Insurance which reported in 2005.



**Figure 1: Current Healthcare Financing in South Africa, drawn using value of expenditure<sup>a</sup>**

#### 4. Learning from Other Countries

One of the first things people tend to do on being faced with reform is to look at how other countries have dealt with healthcare financing issues. A strong word of caution: it is seldom easy to understand another country in sufficient depth to be able to determine whether an element of their system could be successfully adopted in another country. There is not one “best” solution – the current state of any healthcare system is a product of the people, their culture and history, their value systems, changing political ideology over time, economic pressures, the supply of providers and the design and governance of the healthcare system – amongst other factors.

South Africa will need to forge its own path of reform, through consultation and debate. For those who persist in looking for solutions elsewhere, some good authoritative sources are given below.

<sup>a</sup> 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.

Comparative studies of reform can provide useful learnings and several are included below, focussing on material from a wider range of countries than just Europe or North America.

#### 4.1 Healthcare reform in Europe and the Industrialised Countries

An excellent source on the detail of healthcare systems in other countries is the **European Observatory on Health Systems**. The original European Union countries are well covered as well as the emerging countries of Eastern Europe. The collection also includes material on Canada, Israel, Australia and New Zealand. There is limited material on the USA and Japan.

Choose a country from <http://www.euro.who.int/observatory/ctryinfo/ctryinfo>

The **Health Systems in Transition** (HiT) profiles from the European Observatory are particularly useful summaries of each country as they are written using a common template.

See <http://www.euro.who.int/observatory/Hits/TopPage>

**Social health insurance systems in western Europe** is a book summarising the European experience of mandatory health cover. "The concept of social health insurance (SHI) is deeply ingrained in the fabric of health care systems in western Europe."

Saltman, R. B., Busse, R., & Figueras, J. (Eds.). (2004). *Social Health Insurance Systems in Western Europe*. Maidenhead: Open University Press

URL: [http://www.euro.who.int/observatory/publications/20041122\\_1](http://www.euro.who.int/observatory/publications/20041122_1)

**Health Policy Monitor** is an excellent site on details and progress of specific reforms in healthcare. The International Network Health Policy and Reform was initiated in 2002 and brings together health policy experts from 20 industrialized countries. See <http://www.hpm.org/en/index.html>

#### 4.2 Healthcare reform in the WHO Regions

The WHO maintains a site which contains a "selection of countries' experiences with recent health financing policy reforms are included here. The examples, although by no means exhaustive, highlight specific concerns of policymakers from different countries, and related policies to address these concerns." See [http://www.who.int/health\\_financing/countries/en/](http://www.who.int/health_financing/countries/en/)

#### 4.3 Healthcare reform in Low and middle-income countries

The World Bank has produced a volume entitled "Good practice in health financing: lessons from reforms in low and middle-income countries". "This volume focuses on nine countries that have completed, or are well along in the process of carrying out, major health financing reforms. These countries have significantly expanded their people's health care coverage or maintained such coverage after prolonged political or economic shocks ... The countries chosen for the study were Chile, Colombia, Costa Rica, Estonia, the Kyrgyz Republic, Sri Lanka, Thailand, Tunisia, and Vietnam."

Gottret, P., Schieber, G. J., & Waters, H. R. (Eds.). (2008). *Good practice in health financing: lessons from reforms in low and middle-income countries*. Washington: The International Bank for Reconstruction and Development / The World Bank.

URL: <http://siteresources.worldbank.org/INTHSD/Resources/376278-1202320704235/GoodPracticesHealthFinancing.pdf>

See also Gottret, P., & Schieber, G. J. (2006). *Health Financing Revisited: A Practitioner's Guide*. Washington: The International Bank for Reconstruction and Development / The World Bank. URL: <http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf>

## 4.4 Healthcare Reform in Africa

### Health financing: a strategy for the African region

[http://www.who.int/health\\_financing/documents/cov-afrostrategy/en/index.html](http://www.who.int/health_financing/documents/cov-afrostrategy/en/index.html)

The WHO, writing about Africa, says: "Countries of the Region are confronted with a number of key challenges including low investment in health; low economic growth rates; dearth of comprehensive health financing policies and strategic plans; extensive out-of-pocket payments; limited financial access to health services; limited coverage by health insurance; lack of social safety nets to protect the poor; inefficient resource use; ineffective aid; and weak mechanisms for coordinating partner support in the health sector."

The **International Social Security Association** (ISSA) (see <http://www.issa.int/aiss>) established a Liaison Office for Southern Africa in 2008 (see <http://www.issa.int/aiss/About-ISSA/Liaison-Offices>). While the material on the ISSA site is predominantly on pension and social security systems, there is an increasing focus on health systems (see <http://www.issa.int/aiss/Topics/Health>). A report released in 2008 deals with social security developments in Africa. Chapter 3 deals with "Including the poor in social health protection".

International Social Security Association (2008). *Dynamic Social Security for Africa: An Agenda for Development. Developments and Trends*. Geneva. URL: <http://www.issa.int/aiss/Resources/ISSA-Publications/Dynamic-Social-Security-for-Africa-An-Agenda-for-Development>

Prof Di McIntyre of UCT leads a consortium of researchers know as the **SHIELD project** (Strategies for Health Insurance for Equity in Less Developed countries) which considers health insurance mechanisms to address health system inequities in Ghana, South Africa and Tanzania. See <http://web.uct.ac.za/depts/heu/SHIELD/about/about.htm>

### Ghana, South Africa and Tanzania

A paper has recently been published looking at how the three countries are moving towards universal coverage: "The aim of this paper is to explore the extent of fragmentation within the health systems of three African countries (Ghana, South Africa and the United Republic of Tanzania). Using a framework for analysing health-care financing in terms of its key functions, we describe how fragmentation has developed, how each country has attempted to address the arising equity challenges and what remains to be done to promote universal coverage. The analysis suggests that South Africa has made the least progress in addressing fragmentation, while Ghana appears to be pursuing a universal coverage policy in a more coherent way."

McIntyre, D., Garshong, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., et al. (2008). Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bull World Health Organ*, 86(11), 871-876.

URL: <http://www.who.int/bulletin/volumes/86/11/08-053413/en/index.html>

## 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)

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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