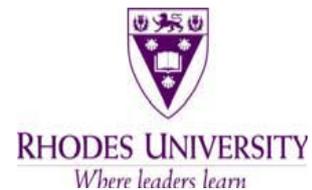


Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care

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**HEALTH
ECONOMICS
UNIT**



**With Institute for Social and Economic Research, Rhodes University
In the Regional Network for Equity in Health in East and
Southern Africa (EQUINET)**

EQUINET DISCUSSION PAPER 84

July 2010

With support from Southern African Trust

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Cite as: McIntyre D (2010) 'Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care,' *EQUINET Discussion Paper Series 84* Health Economics Unit (UCT), ISER Rhodes University, EQUINET: Harare.

Executive summary

The private health sector in South Africa is substantial. This paper explores the private sector involvement in funding and providing health services in South Africa and the implications for equity and access to health care. It was implemented within a programme of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) by the Health Economics Unit University of Cape Town, in a regional programme co-ordinated by the Institute for Social and Economic Research, South Africa, working with Training and Research Support Centre and SEATINI.

Although only 15% of the population is covered by private health insurance (called medical schemes), 44% of total health care expenditure is attributable to these schemes. These financial resources are almost exclusively spent on private for-profit providers, particularly hospitals (36% of scheme spending on health services), specialists (21%), medicines and retail pharmacies (17%), general practitioners (8%), dentists (4%) and a wide range of other providers such as psychologists, physiotherapists and complementary health practitioners (14%). Contributions to medical schemes are also used to cover non-health care costs such as administrative costs, spending on managed care initiatives and insurance brokers' fees. Over and above these contributions, medical scheme members also have to make substantial out-of-pocket payments in the form of co-payments, covering the costs of services not covered by schemes or paying for services once the annual benefits have been exhausted. Medical schemes are, therefore, not providing adequate financial protection for their members.

Serious challenges face the private health care sector in South Africa, not least of all the very rapid increases in expenditure and, hence, contribution rates in medical schemes. Contributions have increased at rates far exceeding general consumer inflation in every year — except 1996 and 2006 — over the past two and a half decades. The average real contribution per medical scheme beneficiary per annum (i.e. after taking into account general consumer inflation) has increased from about R1,800 in 1981 to nearly R9,900 in 2007 (both expressed in 2008 Rand values). The most rapid real increases were experienced between 1997 and 2004, with an increase per beneficiary of nearly 100% in seven years. Medical scheme contributions also increased far more rapidly than average wages and salaries of formal sector workers. In 1981, a household with only one member working in the formal sector devoted just over 7% of average wages to medical scheme contributions to cover themselves and their dependents. By 1991, this had increased to 14% of average wages; by 2001 it again increased to 20%, and in 2007 stood at almost 30%.

A range of factors underlie these trends; but in recent years, schemes' spending increases have been driven largely by private for-profit hospitals and specialists, with the number of private hospital beds increasing rapidly and considerable consolidation of beds within three large private hospital groups. There is effectively an imbalance of power between these hospital groups and the 120 individual medical schemes in their price negotiations. The factors driving rapid increases in contributions to and spending by medical scheme have not been addressed effectively either through government regulation or through action by the private health sector itself. These challenges impact on the overall health system, both in terms of its affordability and sustainability and in terms of the ability to achieve the income- and risk- cross-subsidies required to achieve a universal system. Although South Africa has 'progressive' health care financing, because the high spenders in the medical schemes are in essence spending on their own health, the more fundamental principle of cross subsidies, from rich to poor and from the healthy to the ill, is not being honoured.

The 2007 policy conference of the ruling African National Congress (ANC) resolved to introduce a National Health Insurance (NHI). The proposed NHI aims to achieve universal financial risk protection and access to health care. Implicit in the proposals are strategies to

address the current challenges in both the public and private health sectors. While the proposed funding and pooling mechanism for the NHI is in line with international best practice for universal health systems, many details of the proposed NHI, particularly in terms of the purchasing and provision of health services, are still unclear. Stakeholders have widespread agreement that substantial reform of the health system is needed and all stakeholders have stated their support for a universal system and for reducing the public-private health sector differentials in resources relative to the population served. However, it is critical that careful planning is undertaken, that there is extensive engagement with all stakeholders (particularly the oft-forgotten 'stakeholders' in the form of citizens and front-line health workers and managers) and that implementation occurs over a reasonable timeframe if the proposed reforms are to achieve the goal of a universal health system.

If successfully implemented, the substantial reforms envisaged will promote health system equity, affordability and sustainability within South Africa. However, there are growing concerns that the introduction of these reforms will contribute to increased activities by South African private for-profit health care companies in other African countries. Private health care firms in South Africa not only have an interest in expanding into other African countries, they will also have access to substantial investment resources. In particular, the World Bank's International Finance Corporation (IFC) is actively seeking to invest in the private health sector in African countries. The experience of the private health sector in South Africa should be taken into account by policy-makers in other African countries when considering what role they envisage for the private health sector within their country context.

1. Introduction

This report forms part of a series of evaluations of private sector involvement in the funding and provision of health services in east and southern Africa. The terms of reference for this project were to explore in detail the extent and nature of the South African private health sector, its impact on the overall health system and initiatives to restructure the health system to benefit all who live in South Africa, particularly in relation to implementing a National Health Insurance (NHI). The views of key industry players, actors involved in policy formulation and civil society in relation to NHI are also to be reviewed. Finally, this research explores the significance of these debates for east and southern Africa. Thus, while the primary focus is on the private health sector, this is considered in terms of its inter-relationship with the public sector and its implications for the overall health sector. The paper was implemented within a programme of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) by the Health Economics Unit University of Cape Town, in a regional programme co-ordinated by the Institute for Social and Economic Research, South Africa, working with Training and Research Support Centre and SEATINI.

2. Methodology

This study used a range of methods including literature reviews, analysis of numerical data and analysis of media reports. An extensive literature review was undertaken in relation to:

- information about the extent and nature of the private health sector in South Africa, as well as the critical evaluation of this sector, drawing on a range of publications on this subject (literature was identified through an electronic search of Medline and supplemented with snowballing using the reference lists in the papers identified through the electronic search);
- historical review of policy proposals on mandatory health insurance in South Africa and commentaries on these proposals); and
- critical analysis of NHI debates drawing on international experience (drawing particularly on an extensive review of the international literature on health care financing, with described in McIntyre (2007)).

The section on the current proposals for NHI and the review of stakeholder views on these proposals was based entirely on a review of media reports, a review of parliamentary speeches and a review of information contained on the websites of key stakeholders. These sources were used as there is no policy proposal in the public domain as yet. In relation to media reports, from June the author undertook a weekly review of South African print media online to find reports on the NHI.

Information on the ownership structure of the private health industry in South Africa was derived from websites of each company (e.g. private hospital groups, pharmaceutical companies, etc.).

Empirical data are drawn from a range of sources, including:

- annual reports of the Council for Medical Schemes (CMS, 1981–2007 and 2008a) – this provided data on the number of scheme members, contributions to schemes and expenditure by schemes);
- the Health Systems Trust's *South African Health Review* (HST, 2007; 2008) – this was mainly used for information on health personnel;
- Statistics South Africa's 2005/6 *Income and Expenditure Survey* (IES), which included over 21,000 households – for analysis of medical scheme contributions relative to household income levels and on out-of-pocket payments; and the South African Consortium for *Benefit Incidence Analysis* (SACBIA) survey, which was a nationally representative survey of 4,800 households, undertaken in 2008 by the Health Economics Unit at the University of Cape Town, the Centre for Health Policy at the University of the

Witwatersrand, the national Department of Health (DoH) and the London School of Hygiene — for analysis of utilisation of private sector health services.

3. Current extent and nature of the private health sector

This section provides a detailed overview of current private sector health care financing and provision in South Africa. It also considers population coverage by the private health sector and the extent of utilisation of private sector health services. Finally, it provides some insights into capital flows in terms of identifying the major shareholders of private health organisations and inter-relationships between different private sector organisations.

3.1 Health care financing

3.1.1 Overview of financing mechanisms

The main ways in which private health care services are financed in South Africa are through private health insurance (called medical schemes) and through direct out-of-pocket (OOP) payments. Membership of medical schemes is voluntary, in the sense that there is no law requiring specific individuals or groups to become members of medical schemes. However, in reality membership is not entirely voluntary as contributing to a medical scheme is often a condition of service for formal sector employees. Medical schemes are non-profit associations, governed by Boards of Trustees who are expected to ensure that their scheme acts in the best interests of its members. However, day-to-day management of most schemes is contracted out to large medical scheme administrator organisations, which are for-profit organisations.

In 2007, there were 122 registered medical schemes, compared to 240 registered schemes in 1990 (McIntyre et al, 1995a). Over the past decade and a half, there has been substantial consolidation of schemes, with the number of registered schemes declining by about a third since the early 1990s. There were 23 medical scheme administrators in 2007, but six of these (Discovery Health, Medscheme, Metropolitan Health Group, Old Mutual Healthcare, Momentum Medical Scheme Administrators and Allcare Administrators) account for nearly three-quarters of the administrator market share (measured in terms of the number of medical scheme beneficiaries covered) (CMS, 2008a).

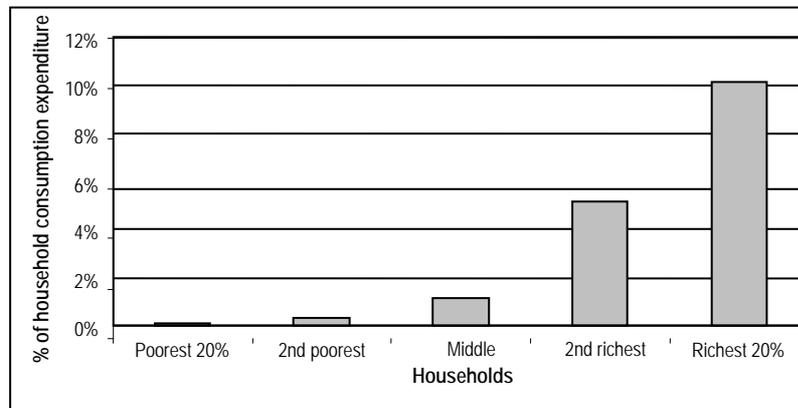
OOP payments are primarily paid to private providers, although a small share of OOP spending is attributable to user fees at public sector hospitals. Medical scheme members make considerable OOP payments; they are expected to make co-payments on certain services (e.g. some schemes require members to pay 20% of the cost of prescription medicines for acute illnesses) and also have to make OOP payments for services not covered by their scheme or when their annual scheme benefits have been fully used. Non-scheme members who choose to use private providers (such as general practitioners, retail pharmacies and traditional healers) have to pay for these services on an OOP basis.

3.1.2 Medical scheme funding and expenditure

In 2007, about R64.7 billion was paid to medical schemes in member contributions. Households bear the burden of these contributions. Many companies in South Africa operate on a 'cost to company' basis, whereby a total package is offered to employees and the full amount of medical scheme contributions is deducted (along with pension contributions, etc.) and the remainder is then paid out as the cash salary. *Figure 1* indicates the distribution of these contributions across socio-economic groups in the entire population, relative to household income (proxied here by consumption expenditure). This information is based on the Income and Expenditure Survey (IES) undertaken in 2005/6 (Statistics South Africa, 2008a). The richest 20% of the population bear the greatest burden of medical scheme contributions, which on average account for slightly more than 10% of household income. This reflects the distribution of medical scheme membership across socio-economic groups,

calculated as total medical scheme contributions as a percentage of total household income (proxied by consumption expenditure) for everyone in that quintile, even though not all households belong to medical schemes, i.e. the percentage of income devoted to medical scheme contributions for individual households generally exceeds the amounts presented in *Figure 1*, except for the very rich.

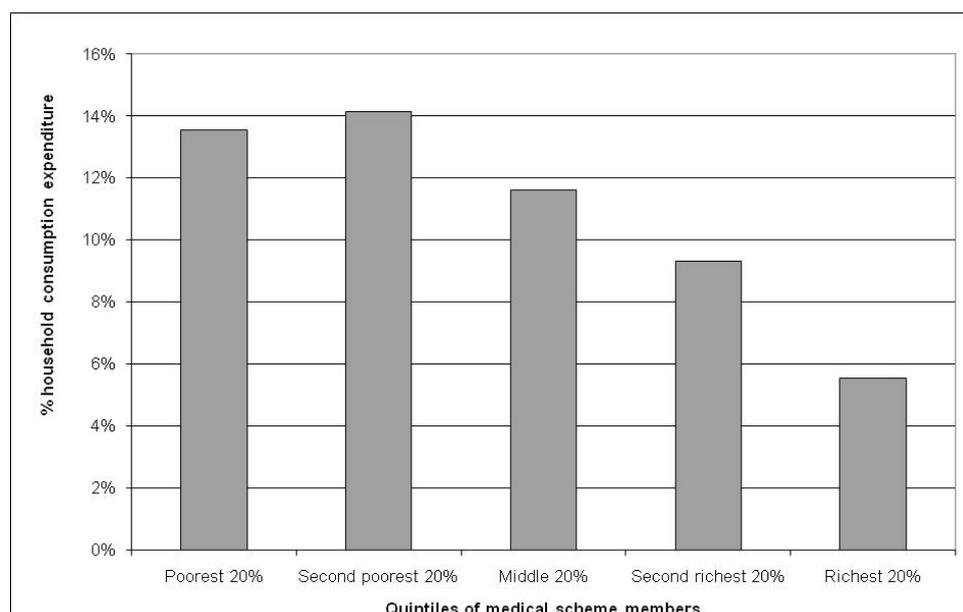
Figure 1: Distribution of scheme contributions across socio-economic groups – average over total population, 2005/6



Source: Ataguba and McIntyre, 2009; data from Statistics South Africa, 2008a

When one restricts the analysis to only medical scheme members, it becomes clear that medical scheme contributions are regressive (see *Figure 2*)¹. The lowest income medical scheme members pay a higher proportion of their household income in medical scheme contributions than the richest scheme members, due to medical schemes charging flat rate contributions, i.e. for each benefit option there is a single contribution for principal members and each additional dependent, irrespective of income level. Although lower-income individuals can choose to register for a lower cost benefit option, the differentiation in contribution levels between benefit options does not match the wide variation in incomes between low- and high-income workers who belong to medical schemes.

Figure 2: Distribution of scheme contributions across socio-economic groups – average over medical scheme members only (2005/06)



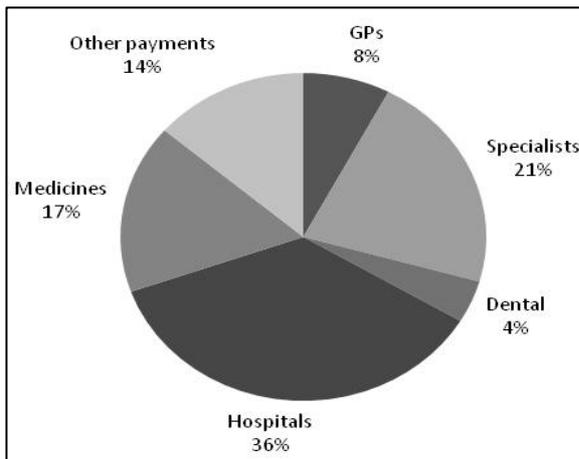
Source: Data from Statistics South Africa, 2008a, analysed by John Ataguba

¹ While *Figure 1* presents quintiles (20% shares) of **all** households in South Africa, *Figure 2* focuses **only on medical scheme members** (mainly in the richest 40% of South Africans). *Figure 2* divides medical scheme members into 20% shares/quintiles.

Government indirectly contributes a substantial amount of funding towards medical scheme contributions as at least a part of the contributions are tax deductible. The most recently published estimate of the value of this tax subsidy is that it exceeded R10 billion in 2005. The way tax deductions are calculated was changed in 2006, and National Treasury estimated that the additional cost of these revisions could be as high as R3.8 billion in the 2006/7 financial year (McIntyre et al, 2005). It is, thus, likely that the value of tax subsidies for medical scheme contributions were at least R14 billion in 2007.

Nearly R57.2 billion was spent by schemes on health services in 2007 (CMS, 2008a). *Figure 3* shows that the largest share of this expenditure was attributable to private hospitals (totalling R20.2 billion), followed by specialists (accounting for over R12.2 billion) and then medicines (R9.4 billion).

Figure 3: Distribution of medical scheme expenditure by type of service provider, 2007



Source: CMS, 2008a

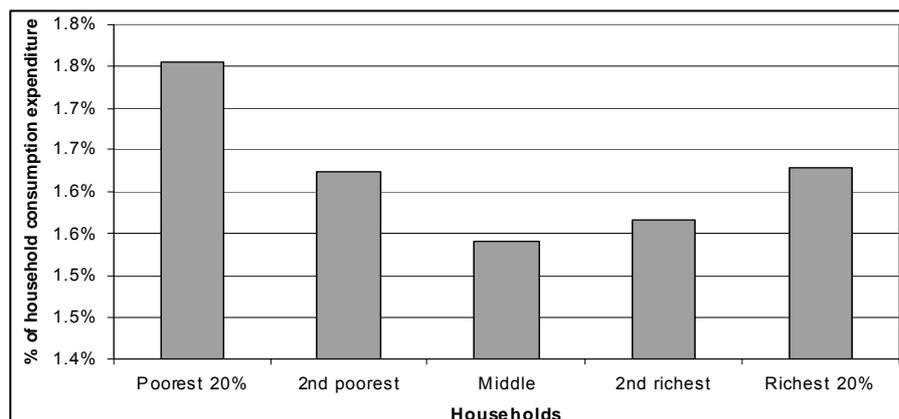
The difference between contributions and health service benefit payments is accounted for by over R1.5 billion on management services for managed care initiatives (such as assessing applications for chronic medicine benefits and for pre-hospitalisation authorisation), R1 billion in brokers' fees (i.e. payments to brokers who sign up members for schemes) and R6.3 billion in administration expenses. These non-health care expenses account for nearly 14% of total medical scheme contributions.

3.1.3 Out-of-pocket payments

Based on information and estimates from the 2005/6 IES (Statistics South Africa, 2008a) and other recent household surveys (particularly SACBIA, 2008), over R20 billion was spent on OOP payments in 2007. Most (almost 93%) OOP payments are paid to private sector providers, and more than 60% of OOP payments are made by medical scheme members. This highlights that although medical schemes provide some protection against the cost of health care, there remain financial protection concerns as medical scheme members have to make substantial OOP payments over and above monthly medical scheme contributions.

Figure 4 shows that OOP spending is a regressive funding mechanism, i.e. they impose a greater burden (as a percentage of household income, proxied by household consumption expenditure) on the poorest households. However, as medical scheme members (mainly in the richest 40% of the population) make large OOP payments, this translates into a higher burden of OOP payments for this group than for the middle 20% of households.

Figure 4: Distribution of OOP payments across socio-economic groups, 2005/6

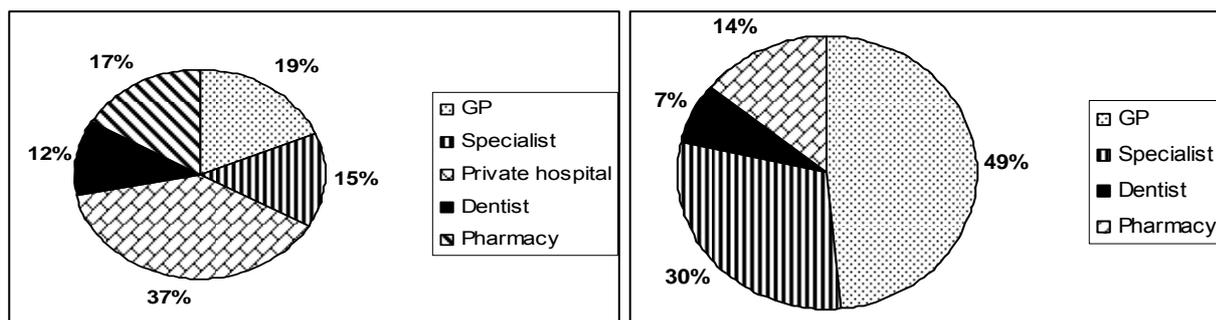


Source: Ataguba and McIntyre, 2009; data from Statistics South Africa, 2008a

Figures 5 and 6 show that for medical scheme members, payments to private hospitals account for the largest share of their OOP payments, followed by general practitioners (GPs), pharmacies, specialists and dentists. Those not covered by medical schemes, pay almost half their OOP payments to GPs, followed by specialists and pharmacies.

Figure 5: Distribution of OOP payments by medical scheme members across different private sector services, 2008

Figure 6: Distribution of OOP payments by non-members across different private sector services, 2008



Source: SACBIA, 2008 data analysed by John Ataguba

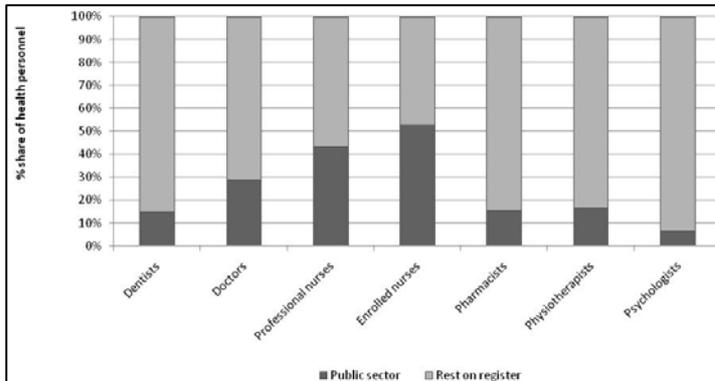
3.2 Health service provision

A wide range of health services are provided by the private sector in South Africa, including: independent practitioners working in solo or group practice (e.g. GPs, dentists, psychologists and physiotherapists), pharmacists at retail pharmacies, specialist doctors (who generally have consulting rooms in private hospitals), private hospitals which employ nurses and other health professionals and ambulance services. Traditional healers are another important private provider, but due to data constraints, they are not considered here. It is difficult to determine exactly how many health professionals work in the private health sector, as the only sources of data are the respective professional councils such as Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC) and South African Pharmacy Council (SAPC). All health professionals must register with their respective council every year, but do not indicate if they are working in the country (some health professionals working abroad maintain their South African registration), and if they are in the country, in which sector they work. Some retired professionals also maintain their registration.

Figure 7 compares the number of different types of health professionals working in the public sector with the remainder of professionals registered with one of the relevant councils. It clearly shows that few health professionals — except nurses — work in the public health sector in South Africa. Although some of those not working in the public sector may be working abroad, it is clear that most health professionals (except enrolled nurses) work in the

private health sector. In addition, some health professionals work in both the public and private sector, either under government sanctioned remunerated work outside public service (RWOPS) in the case of specialists, or in the form of ‘moonlighting’.

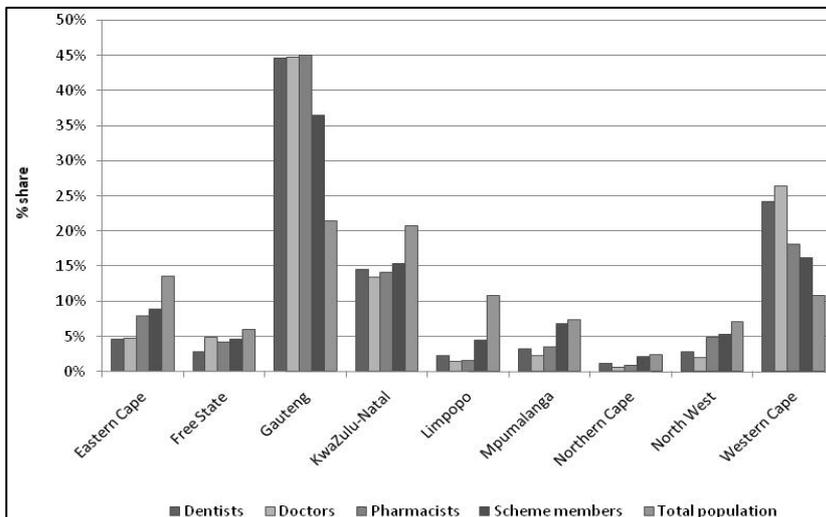
Figure 7: Estimate of the public–private mix of various health professionals, 2007



Source: Day and Gray, 2008

Figure 8 shows the provincial distribution of doctors, dentists and pharmacists registered with a professional council but not working in the public sector. While some may have retired or be working abroad, most work in the private sector in South Africa. The distribution of health professionals is compared with the distribution of medical scheme members (the main users of private sector services) and the total population. Private sector health care professionals are heavily concentrated in provinces with the largest metropolitan areas, namely Gauteng and the Western Cape; while Gauteng has only 21% of the total population and 37% of medical scheme members, 45% of private sector doctors, dentists and pharmacists work there. All other provinces have a smaller share of private sector health professionals than their share of population or medical scheme members.

Figure 8: Provincial distribution of key health professionals in private sector, 2007



Source: Health professionals: Day and Gray, 2008; Provincial population: Statistics South Africa, 2008b; Provincial distribution of medical scheme members: CMS, 2008a

The distribution of private hospital beds is similarly skewed in favour of provinces with metropolitan and other large urban areas (see Table 1). There are 28,361 beds in 205 private hospitals in South Africa. As use of these hospitals is almost entirely restricted to medical scheme members, this translates into 38 beds per 10,000 scheme members.

Table 1: Distribution of private hospital beds relative to total and medical scheme population distribution, 2008

Province	Beds	% share of beds	% share of total population	% share of medical scheme members
Eastern Cape	1,522	5.4%	13.5%	8.9%
Free State	1,630	5.7%	5.9%	4.6%
Gauteng	13,550	47.8%	21.5%	36.5%
KwaZulu Natal	4,315	15.2%	20.8%	15.3%
Limpopo	333	1.2%	10.8%	4.4%
Mpumalanga	987	3.5%	7.4%	6.8%
North West	1,564	5.5%	7.0%	5.3%
Northern Cape	343	1.2%	2.3%	2.1%
Western Cape	4,117	14.5%	10.8%	16.2%

Sources: Hospital bed numbers: van den Berg, 2009; Provincial population: Statistics South Africa, 2008b; Provincial distribution of medical scheme members: CMS, 2008a

Most (over 76%) of these beds are in hospitals owned by three private hospital groups (see *Table 2*). There is, therefore, a high level of concentration of private hospital bed ownership. Two of these private hospital groups, Life and Medi-Clinic, currently own private hospitals in neighbouring countries (Botswana and Namibia respectively). Netcare recently embarked on a hospital project in Lesotho and is exploring options in other African countries.

Table 2: Distribution of private hospital beds between hospital groups, 2008

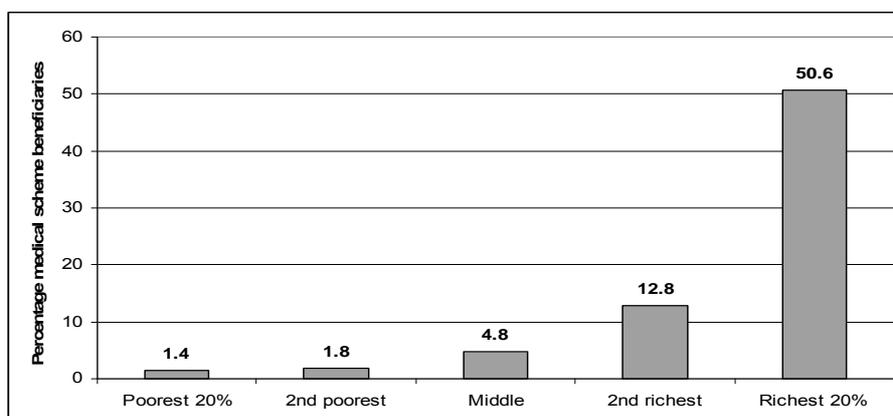
Hospital group	Hospitals	Beds	% share of beds
Netcare	49	8,685	30.6%
Life	49	7,101	25.0%
Medi-Clinic	40	5,983	21.1%
Independent	67	6,592	23.2%

Source: van den Berg, 2009

3.3 Population coverage and service utilisation

About 15% of the South African population are beneficiaries of medical schemes. As suggested by *Figure 1*, membership of medical schemes is heavily concentrated in the richest socio-economic groups. A recent national household survey found that more than half of the richest 20% of the population were beneficiaries of medical schemes, as was about 13% of the second richest quintile (see *Figure 9*). Very few people in lower socio-economic groups were covered by medical schemes (often a single household member who worked in low-wage formal sector employment).

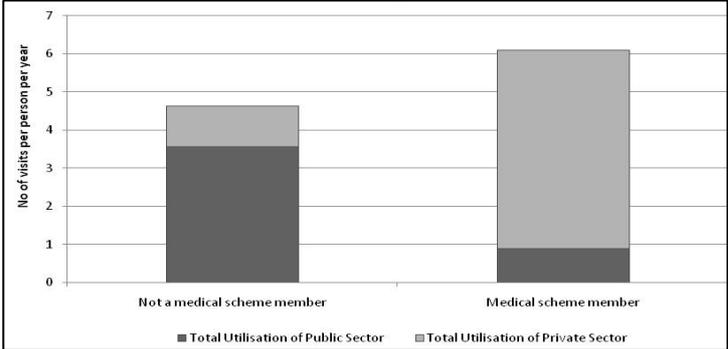
Figure 9: Percentage of each socio-economic group covered by medical schemes



Source: McIntyre et al, 2008

Those covered by medical schemes mostly use private sector health services (Figures 10 and 11). However, medical scheme members do sometimes use public hospitals, particularly for inpatient care and often at the most highly specialised hospitals (McIntyre et al, 2008). Some South Africans not covered by medical schemes use the services of private providers for out-patient services and pay for this on an OOP basis. The most recent household survey to provide such information (SACBIA, 2008) indicates that less than 20% of non-scheme members used 'formal' private providers for outpatient care (i.e. excluding traditional and faith-based healers). The formal private providers most often used by those who are not medical scheme members are private GPs and private pharmacies (traditional and spiritual healers are also used by this group) (McIntyre et al, 2008).

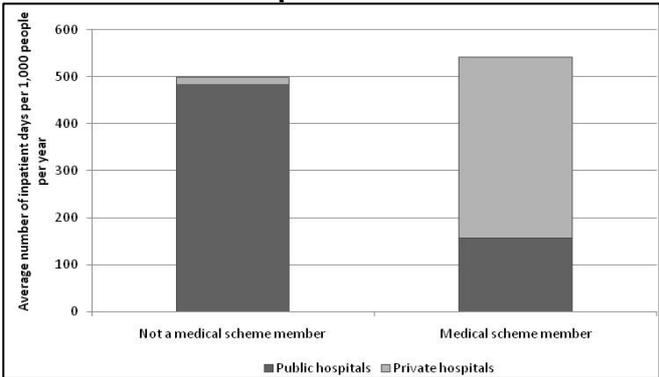
Figure 10: Utilisation rates of public and private providers for outpatient care by medical scheme membership status



Source: McIntyre et al, 2008

There is almost no utilisation of private hospital inpatient services among those not covered by medical schemes (Figure 11). On the basis of available information, it can confidently be stated that only 15% of the population (i.e. medical scheme members) use private sector hospitals, and at most about 32% of the population (i.e. the 15% of the population who are medical scheme members plus 20% of the 85% who are not medical scheme members) use outpatient services in the private sector. However, only medical scheme members have access to the full range of private sector outpatient services, while the 20% of non-scheme members who may pay OOP for care in the private sector are largely restricted to general practitioner and retail pharmacy services but sometimes specialists as well.

Figure 11: Utilisation rates of public and private hospitals for inpatient care by medical scheme membership status



Source: McIntyre et al, 2008

3.4 Ownership structure of the industry

There are three components of the private health sector that involve the largest 'capital flows', or expressed differently, involve considerable capital investment in organisations that operate on a for-profit basis. These are: medical scheme administrators, private hospital groups and pharmaceutical companies. This section provides information on the main South

African companies in these categories, particularly in relation to their ownership structure and size of annual turnover and gross profit. Unfortunately, it is difficult to obtain comprehensive information on the ownership structure of these companies as they are only required to disclose the distribution between categories of shareholders (e.g. banks, public companies) rather than reveal the precise organisations or individuals that are shareholders.

3.4.1 Medical scheme administrators

The seven largest medical scheme administrators account for nearly three-quarters of medical scheme members. These administrators are listed according to their share of medical scheme members covered by them:

Discovery Health	27.7%
Metropolitan Health Group	18.4%
Medscheme Holdings	14.1%
Old Mutual Healthcare	7.1%
Momentum Medical Scheme Administrators	4.0%
Allcare Administrators	2.6%
Rowan Angel	2.5%

Table 3 summarises the key ownership information that could be located on these companies. This information shows that the two largest medical scheme administrators are owned by large financial services institutions. It also shows that there is considerable concentration of ownership in the medical schemes administration industry. For example, FirstRand (primarily involved in banking, owning First National Bank, Rand Merchant Bank and WesBank) wholly own the Momentum Group, to which Momentum Medical Scheme Administrators belong, but they also own a considerable shareholding in the Discovery Group. Another example of concentration is the ownership of Medscheme, Old Mutual Healthcare and Rowan Angel by Lethimvula Investments.

Table 3: Summary of ownership and financial information of largest medical scheme administrators in South Africa

Administrator	Ownership structure
Discovery Health	Part of the Discovery Group, a financial services institution Largest shareholders of Discovery Group: Public companies (25% of shares), pension funds (15%), mutual funds (12%), private companies (11%), trusts (8%), BEE (6%), investment companies (6%), individuals (5%), others (including banks - 12%)
Metropolitan Health Group (MHG)	Subsidiary of Metropolitan Holdings Limited, a financial services institution (which includes the fourth largest life assurer in SA). Largest shareholders: collective investment schemes and mutual funds (35%), Kagiso Trust Investments (24%), pension funds (22%), banks and insurance companies (12%)
Medscheme Holdings	Lethimvula Investments Limited owns 88% of Medscheme (took control in 2006) Has a strategic partnership with Discovery in a joint venture (Healthbridge/Sigma Health)
Old Mutual Healthcare	Was a wholly owned subsidiary of Old Mutual until late 2008; Lethimvula Investments acquired 100% of Old Mutual's interest in OM Healthcare
Momentum Medical Scheme Administrators	Part of Momentum Group, which is a wholly owned subsidiary of FirstRand Limited, one of the largest financial services groups in SA
Allcare Administrators	Privately owned company
Rowan Angel	Owned by Lethimvula Investments*

*Lethimvula is a Black Economic Empowerment (BEE) company. The Board of Directors is chaired by Anna Mokgokong, a medical doctor who is also a director of several other health care-related companies (e.g. Air Liquide Healthcare, Novartis SA, Phambili Health Care, Malesela Hospital Group). The Lethimvula shareholding includes key doctor groups as follows: ●Community Healthcare Holdings (Pty) Limited: 100% black-owned investment holding company with interests in health (pharmaceutical and medical equipment companies and public-private partnerships (PPPs) at Pelonomi and Universitas hospitals through a joint venture with Netcare), mining and technology sectors – 27.9%; ●Golden Pond Trading 175 (Pty) Limited: holds the interests of the South African Medical and Dental Practitioners Association (SAMDP), which represents more than 3 000 black doctors – 27.9%; ●Bophela Investments Limited: represents members of the South African Managed Care Co-operative (SAMCC) — a voluntary membership of 3 500 doctors, of whom more than 60% are historically disadvantaged individuals – 2.7%; ●Beyond Discovery Investments (Pty) Limited: holds interests of key transaction initiators - 4.6%; and ●Public shareholders: about 8 800 public shareholders hold the remaining 36.9%.

As an indication of the profitability of these medical scheme administrators, Discovery Health's operating profit grew by 21% to R891 million in 2007/8 financial year (equivalent to 5.4% of the value of Discovery members' contributions of R16.6 billion), while Metropolitan Health Group recorded an operating profit in 2008 of R142 million (R100 million after tax). Lethimvula recorded over R1 billion in operating revenue (turnover) from health care administration and managed health care activities in the 2007/8 financial year.

3.4.2 Private hospital groups

The three largest private hospital groups in South Africa are Netcare (31% of beds), Life Healthcare Group (25% of beds) and Medi-Clinic (21%). Netcare Limited has been listed on the Johannesburg Stock Exchange (JSE) since late 1996. Its subsidiaries include:

- the largest private hospital networks in both South Africa and the United Kingdom;
- 87 retail and hospital pharmacies;
- Netcare 911 — the largest private emergency service in South Africa, with over 200 emergency response vehicles and ambulances, three helicopters and two fixed-wing air ambulances;
- primary care provision through managed care centres (108 Medicross and Prime Cure Medicentres, including twelve day theatres); and
- several PPPs, including co-location agreements with various public hospitals in South Africa and for the building of a hospital in Lesotho (Netcare, 2009).

The Netcare Group recorded revenue of nearly R22 billion for the 2007/8 financial year (48% from its South African business and 52% from its UK interests), and an operating profit of over R3 billion. The limited available information on Netcare shareholding indicates that investment and trust companies own 54% of the shares and 'companies' own 31%.

Life Healthcare Group (found at www.lifehealthcare.co.za), in addition to its network of private hospitals, includes:

- Life Esidimeni, which comprises operating 5,300 long stay chronic care beds (psychiatric, tuberculosis and frail care) in fourteen facilities and 400 beds in two district hospitals on a contract basis for provincial governments;
- Life Occupational Health, which includes 257 customer owned on-site clinics and eighteen mine health facilities;
- Life Rehabilitation consisting of four acute physical and cognitive rehabilitation units; and
- Life Healthcare College of Learning — a nursing school with 1,000 students, that provides training to nursing auxiliaries, enrolled nurses and registered nurses, as well as specialist training (critical care, theatre nursing, etc.).

Medi-Clinic (www.mediclinic.co.za) has an extensive network of facilities throughout South Africa, but particularly concentrated in the Western Cape and Gauteng. It also owns:

- three private hospitals in Namibia;
- the largest private hospital group in Switzerland (consisting of thirteen hospitals);
- two hospitals and four clinics in the United Arab Emirates and one clinic in Oman;
- ER24, an emergency and ambulance organisation with over 130 response vehicles;
- Medical Innovations, a company that manufactures hospital equipment; and
- Medical Human Resources — an agency to place temporary and permanent staff (nurses, medical and administrative staff) in private hospitals in South Africa and the United Arab Emirates, with over 16,000 staff on their database.

In the 2008/9 financial year, Medi-Clinic recorded revenue/turnover of over R16 billion and an operating profit of over R2.7 billion. The largest single shareholder is Remgro (formerly the tobacco company Rembrandt Group, but now having interests in sectors such as banking and financial services, printing and packaging, mining, petroleum products, food, wine and spirits) with 43% of the shares. Public shareholders own a further 32% of shares, BEE shareholders have 13% of shares (mainly Phodiso with 6.6% of shares and Circle Capital with 4%), and Trilantic Capital Partners (previously Lehman Brothers) with 10% of shares.

3.4.3 Pharmaceutical manufacturer groups

The two largest South African owned pharmaceutical manufacturers are Aspen-Pharmacare and Adcock Ingram. Aspen (Aspen Holdings, 2009) is Africa's largest pharmaceutical manufacturer and the largest generics manufacturer in the southern hemisphere. It has eleven manufacturing sites (four in South Africa, two in East Africa, two in India and three in Latin America) and business interests in South Africa, Australia, India, Brazil, Mexico, Venezuela, Kenya, Tanzania, Uganda, Mauritius and the United Kingdom. In 2008, it recorded revenue of R4.9 billion and an operating profit of R1.4 billion. The major shareholders of Aspen (i.e. those with more than 5% of shares) are: the Chemical, Energy, Paper, Printing, Wood and Allied Workers Union (CEPPWAWU) (5%); the Public Investment Corporation (6%); Allan Gray Asset Management (9%); and Pharmacare Ltd (10%). Aspen directors, particularly Stephen Saad (Chief Executive) and Gus Attridge (Deputy-Chief Executive), also own substantial shares.

Adcock Ingram (2009) has a large over-the-counter (OTC) medicine component, but also produces prescription medicines and hospital products. Adcock Ingram had a turnover of R3.3 billion in 2008 — R1.1 billion was related to OTC medicines, R1 billion to prescription medicines, and R1.2 billion to hospital products. Key shareholders are: mutual funds (22%); banks (17%); pension funds (14%); investment companies (mainly the Public Investment Corporation) (13%); insurance companies (8%); and public companies (7%).

3.4.4 Key issues

There is evidence of sizeable concentration in the private health care industry in South Africa, in terms of three large private hospital groups, a handful of pharmaceutical manufacturers, and a number of different medical scheme administrators owned by one company. The full extent of vertical integration could not be untangled due to limited disaggregated shareholder information, but it is likely that certain banks and investment companies have large shareholdings across medical scheme administrator, private hospital and pharmaceutical manufacturer groups. For example:

- two of the largest private hospital groups (Netcare and Medi-Clinic) each own the two largest private emergency response groups (Netcare 911 and ER24 respectively) (see www.netcare.co.za and www.mediclinic.co.za);
- private health care providers (doctor groupings and private hospitals) and organisations with interests in pharmaceutical and medical equipment manufacturers are investing in medical scheme administrators (particularly via Lethimvula) (see www.medscheme.co.za and www.lethimvula.co.za); and
- one of the largest private hospital groups (Medi-Clinic) runs the largest private health professional employment agency (see www.mediclinic.co.za).

Many South African owned private health care companies also have considerable business interests outside of South Africa. In some cases this is restricted to other African countries or low- and middle-income countries in Asia or Latin America, but in others, it also includes high-income countries such as Australia, the United Kingdom and Switzerland. There has been a growing diversification of business interests in recent years to the extent that in some cases (e.g. Netcare) the major share of turnover is now from external business interests.

4. Critical evaluation of private health sector

This section evaluates the key challenges facing the private health sector, focussing on changes in the private health sector over the past decade or more and the drivers of these trends. We then consider how the private health sector impacts on the overall health system in South Africa, which provides a basis for considering recommendations for major health system change, in the form of introducing a National Health Insurance (NHI) in section 5.

4.1 Extent of expenditure increases in medical schemes

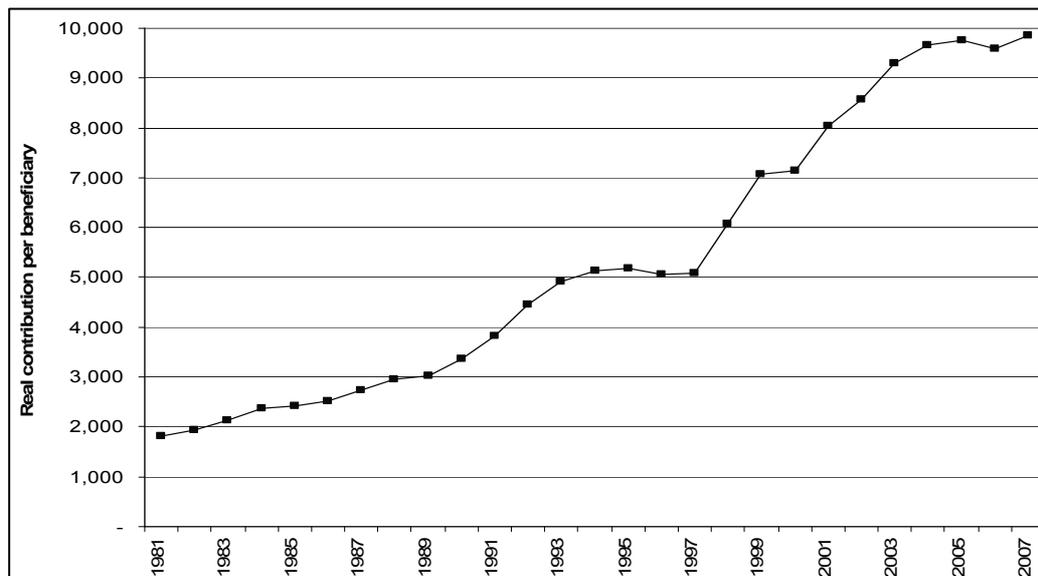
Possibly the greatest challenge facing the private health sector is the rapid increase in spending, particularly by medical schemes. Medical schemes operate on a 'pay as you go' basis, i.e. contribution revenue roughly approximates spending on health services, administration and related activities in any year. As spending increases, so do contributions.

However, contributions to medical schemes have far exceeded inflation rates in the past two and a half decades — except in 1996 and 2006, when contribution increases did not exceed the consumer price index (CPI). *Figure 12* shows increases in medical scheme contributions over and above CPI, i.e. increases in real terms. Scheme contribution increases exceeded CPI by an average of 7.9% annually between 1981 and 1990, by 8% per year between 1991 and 2000, and by an average of 3.5% annually between 2001 and 2007. In some years, contribution increases were very large, such as exceeding inflation by 19.6% in 1998 and 16.6% in 1999.

In nominal terms (i.e. actual increases — some of which may result from general inflation), annual medical scheme contributions per beneficiary increases:

- exceeded 30% in 1991 (31%) and 1992 (32%);
- equalled or exceeded 25% in 1984 (25%), 1987 (26%), 1990 (27%) and 1998 (28%); and
- exceeded 20% in 1982 (22%), 1983 (24%), 1986 (24%), 1988 (21%), 1993 (21%) and 1999 (23%).

Figure 12: Real average medical scheme contribution per beneficiary per year, 1981–2007 (2008 base CPI)



Sources: Total contributions and medical scheme beneficiaries: CMS, 1981–2007; Consumer Price Index: Statistics South Africa, 1981–2007

In effect, medical scheme members have been faced with substantial increases — far greater than general inflation — in their contribution rates on an annual basis for an extended period. Although there was a period of respite from increases in the mid-1990s, this was followed by huge increases in 1998 and 1999. There is no guarantee that this trend will not be repeated in the next few years, to follow on from the constrained contribution rate changes since 2004. The average real contribution per medical scheme beneficiary per year has increased from about R1,800 in 1981 to nearly R9,900 in 2007 (both expressed in 2008 Rand values). Expressed differently, after taking into account the effect of general inflation, medical scheme contributions have increased five-fold in the past two and a half decades. The most rapid real increases were experienced between 1997 and 2004, with an increase in the real per beneficiary contribution rate of nearly 100% in seven years.

The profound implication of annual increases in medical scheme contribution rates above CPI is possibly best seen in relation to average wages. To explore the relationship of medical scheme contributions to average wages, and how this has changed over time, total scheme contributions for the principal member plus their dependents can be compared with average wages of formal sector workers. Unfortunately, no trend data on the average wages and salaries of medical scheme members over time exists, so average wages of all formal sector workers (whether or not they are scheme members) has to be used. The average number of dependents per principal member decreased from 1.65 dependents per principal member in the early 1980s, to 1.36 dependents per principal member in 2007.

A household with only one member working in the formal sector would have had to devote just over 7% of average wages to medical scheme contributions in 1981 (to cover ± 2.65 beneficiaries²). This increased to 14% of average wages by 1991, 20% by 2001 and almost 30% by 2007. Not only have annual increases far exceeded CPI, they have also outstripped the rate of increase in average formal sector wages. Medical scheme contributions thus impose a sizeable burden on the average working household in South Africa.

This does not reflect the actual percentage of medical scheme members' wages devoted to medical scheme contributions as the calculation is based on the average wages of all formal sector workers and not only those who are medical scheme members. Most formal sector workers who belong to medical schemes fall into the higher income bracket. The IES indicates that contributions are about of 9% of household income (which includes wages and other income such as interest from investments) for medical scheme members, but vary significantly from less than 6% for the highest income medical scheme members to 14% for the lowest income members (see *Figure 2*).

Nevertheless, the fact that medical scheme contributions are currently 30% of average formal sector workers' wages is significant, as it explains why medical schemes have found it impossible to extend coverage to lower income workers over the past decade or more. More importantly, it shows why a Social Health Insurance (SHI) option is unlikely to be feasible in South Africa at this point in time. (In the early 1990s, a SHI to cover all formal sector workers and their dependents (via medical schemes) was seen as a possible way to address challenges in the health sector. The lowest income workers who are currently not medical scheme members would be drawn into a SHI.) If a SHI were introduced using the current medical scheme model, SHI contributions would be about 30% of average wages — this is likely to be a realistic estimate of the burden of SHI contributions: even though contribution rates of the newly insured would approximate those of the lowest cost schemes currently available, SHI would still amount to an average 30% of wages, because SHI would be required to cover all dependents, while current medical schemes do not.

Unfortunately there are no reliable trend data on OOP payments. This prevents a similar analysis of these payments as provided above for medical schemes. However, it is known that these payments have also been increasing quite rapidly as medical schemes have introduced more co-payments and as benefit packages, particularly for 'day-to-day' expenses, have become more restricted.

4.2 Factors contributing to expenditure increases

As indicated earlier, contribution increases occur because spending by medical schemes has increased; schemes have to ensure that contribution revenue approximates spending levels each year. But, what aspects of medical schemes expenditure has been rising and why?

² The principal member plus average of 1.65 dependents per principal member = 2.65 beneficiaries

4.2.1 Increased spending on medicine

In the 1980s through to the early 1990s, the largest increases in spending by medical schemes related to medicines, followed by private hospitals and then specialists. Increased spending can arise from both increases in unit costs (i.e. the fees charged by providers) and increases in utilisation. Previous research highlighted that a key reason for increased spending on medicines in the 1980s to early 1990s was the growth in dispensing by medical practitioners (i.e. instead of writing a prescription for a patient to take to a pharmacy, doctors began dispensing and selling medicines directly to patients). In 1988, 4,400 doctors were registered to dispense medicines and this nearly doubled by 1992 when over 8,300 were registered as dispensing doctors (McIntyre et al, 1995a). More and more medicines, and more expensive medicines, began to be dispensed by doctors. The cost of medicines dispensed by general practitioners per medical scheme beneficiary increased from R85 in 1985 to R233 in 1990 (ibid).

Part of the explanation for doctors increasingly taking on a dispensing role, was that the fee being paid to general practitioners by medical schemes was tightly controlled in the 1980s and early 1990s. At the same time, the number of doctors practicing in the private sector was rapidly increasing. In the early 1980s, about 40% of doctors worked in the private sector (Naylor, 1988). By 1990, 62% of general doctors and 66% of specialists were in private practice (Rispel and Behr, 1992). However, the population being served by private doctors was not increasing much (either in terms of people covered by medical schemes or in terms of those not covered by schemes but able to occasionally visit a GP and pay on an OOP basis). Dispensing and selling medicines by medical practitioners was a way to ensure an acceptable income for private doctors.

Private hospitals also contributed to the rapid increase in spending on medicines, as they were able to secure substantial discounts from pharmaceutical manufacturers, but sold these medicines to patients at full retail price. As became clear during court cases in 2004, which challenged newly introduced medicine pricing regulations, a large share of private hospitals' profit was generated from the sale of medicines. This provided an incentive to sell as many medicines as possible, as well as to focus on more expensive medicines.

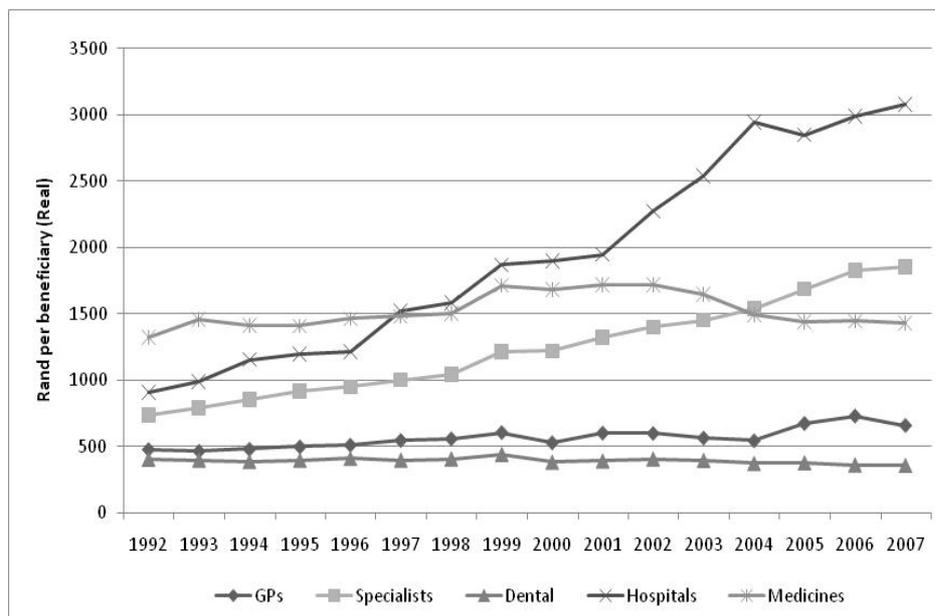
Increased spending on private hospital services (over and above their sale of medicines) was related to a rapid growth in the number of private for-profit hospitals. The number of beds in such hospitals increased from 9,825 in 1988 to 18,432 in 1993 (McIntyre et al, 1995a). Doctors, who ultimately decide on hospital admissions, have a stake in the financial performance of some hospitals through share ownership or other forms of financial relationships, such as rent-free or subsidised consulting rooms within hospitals. This may encourage higher levels of hospitalisation, longer periods of admission and greater use of expensive diagnostic technology provided in these hospitals.

Figure 13 illustrates the trend in spending on different health services by medical schemes over the past decade and a half. These figures are expressed in terms of real spending per medical scheme beneficiary, so reflect spending increases over and above general inflation and that are not associated with any change in medical scheme membership numbers. It is very clear from this figure that spending increases over this period have been largely driven by private for-profit hospitals and specialists. By 1997, private hospitals had overtaken spending on medicines as the largest component of medical scheme spending.

Spending on medicines levelled off for most of the 1990s and then decreased in real per beneficiary terms. Several factors contributed to this including efforts by medical schemes to actively manage chronic medicines for members; those with a chronic illness had to register a request for approval of their medication with the scheme and the scheme would generally approve the least cost alternative. Legislation was also introduced requiring pharmacists to offer a generic substitute of prescribed medication to patients. There has been a dramatic increase in use of generic products over the past decade. Regulations, in early 2004,

introduced price control on medicines and outlawed discounting, so manufacturers were required to sell at a 'Single Exit Price' (i.e. the same price to all purchasers).

Figure 13: Trends in real spending on different health services by medical schemes, 1992–2007 (2008 base CPI)



Sources: Total expenditure and medical scheme beneficiaries: CMS, 1992–2007; Statistics South Africa, 1992–2007

Previously, purchasers such as private hospitals and dispensing doctors were granted enormous discounts (up to 80% of the stated price) to ensure that their product was included on the hospital formulary or dispensed by doctors. Small retail pharmacies, particularly in rural areas, paid the highest price for medicines. These discounts were not necessarily passed on to consumers. The introduction of a Single Exit Price, set at the level of the previous list price less the value of previous discounts, translated into an average price decrease of about 22% (McIntyre et al, 2007).

4.2.2 High cost services and fee increases in private hospitals

The growth of private-for-profit hospitals has continued unabated, with the number of private hospital beds increasing from 18,432 in 1993 to 28,361 beds in 2007, with similar effects to those seen in the late 1980s and early 1990s. There are also more private hospital beds relative to the population served (almost wholly medical scheme members – see *Figure 11*) than many OECD countries (CMS, 2008b). Annual CMS reports recently highlighted that private hospitals were performing more high cost services, e.g. Caesarean sections, magnetic resonance imaging (MRI) and computed tomography (CT) scans and angiograms. When private hospitals buy expensive high-technology equipment (mainly to attract the best specialists to their hospital) substantial pressure is applied on clinicians to use the equipment to earn hospital revenue. The South African private sector has more MRI and CT scanners per million population than countries like Canada, France, Germany, the Netherlands, Sweden and UK) (CMS, 2008b). Effectively, the private hospital market is heavily over-capitalised.

Prices of various private hospital services (e.g. ward fees, theatre costs, etc.) have also greatly increased in the past few years. Private hospital beds owned by three large hospital groups now exceeds three-quarters of all private hospital beds. As shown in a submission to the Competition Commission (van den Heever, 2007), there are clear indications that these groups are using oligopoly power to charge excessively high prices, and not to engage in price competition with each other.

Recent fee increases at private hospitals are driven by the mismatch in power between the three large hospital groups dominating the private hospital market and the 120 individual medical schemes. Initially, the Representative Association of Medical Schemes (RAMS) — now called the Board of Healthcare Funders (BHF) — annually published a list of recommended fees that medical schemes used as the basis for reimbursing providers. At the same time, various professional associations (e.g. representing doctors or dentists) published recommended fees for their members to charge — usually much higher than the RAMS/BHF fees. Nevertheless, at first, many providers charged RAMS/BHF fees so that medical schemes would fully reimburse their bill and providers did not have to rely on patients to pay and claim back from their medical scheme, so a provider could avoid ‘bad debts’ or unpaid bills (McIntyre et al, 1995a). Over time, however, providers judged it more profitable to run the risk of incurring some bad debts but being able to charge any fee they wished (McIntyre et al, 2007).

In the early 2000s, the Competition Commission ruled that it was anti-competitive for a body like BHF or a professional association (like SAMA) with no statutory to publish a fee schedule (Competition Commission, 2009). Although the *National Health Act 61 of 2003* makes provision for a National Health Reference Price List (NHRPL), which recommends fees for different health services provided by private practitioners or hospitals, these are not mandatory, so the over 120 individual schemes have to negotiate with the oligopoly of three large private hospital groups.

Increases in spending on specialists are also related to utilisation and fee increases. The Health Professions Council particularly contributed to fee increases by generalist and specialist doctors, when it stated in 2004 that it would regard a fee of up to three times the NHRPL fee to be ethical, when considering patient complaints about excessive charges. Doctors have interpreted this as a signal, and most (particularly specialists) started charging 300% of the NHRPL fee since the council decision (van den Heever, 2007).

4.2.3 The ageing population

Over the years, medical schemes and private providers have regularly attributed health care spending and contribution increases to ageing of the population (Fourie and Marx, 1993). This can be partly assessed by considering the proportion of medical scheme members who fall into the category of pensioners. There was a quite dramatic change in this indicator in the late 1980s; in 1986, 5.3% of scheme beneficiaries were pensioners, which had increased to 7.2% by 1992 (McIntyre et al, 1995b). However, in 2007, only 6.2% of scheme members were pensioners. The average age of medical scheme members in 2007 was 31.4 years (down from 31.6 in 2006) (CMS, 2008a). A recent analysis of medical schemes expenditure found that ageing of the population is only a minor contributor to increased spending (CMS, 2008b).

4.2.4 Third party payments

All things considered, the heart of the problem of expenditure increases in the medical schemes sector is reimbursement of private for-profit health care providers by a ‘third-party payer’ (medical schemes) on a fee-for-service basis. The notion of a third-party payer relates to the fact that a health care provider (e.g. a doctor or a hospital) provides services to patients, but a ‘third-party’ pays the provider for this service on behalf of the patient. Since these payments take the form of fee-for-service, provider earnings are directly related to the volume of services provided, so there is a clear economic incentive to providers to increase the number and type of services provided (so-called supplier-induced demand). As payments are made by a ‘third-party’, providers are less concerned about the impact of such practices on their patients, who are not paying them directly. At the same time, patients are less likely to question the diagnosis and treatment advice of a provider and may use health care providers more frequently and intensively than they would if they were paying the provider directly. This web of perverse incentives arising from fee-for-service payments by a third-

party is exacerbated by the growing power imbalances between schemes and providers, which allows providers to unilaterally increase their fees.

4.2.5 Non-health care costs

It is also important to recognise that contribution increases are not only attributable to increased spending on health services but also to increases in non-health care costs. At present, administration costs account for just under 10% of total medical scheme spending. However, a further 9% is attributable to managed care activities and brokers' fees (CMS, 2008b). Although there is no legislated maximum administration charge, for decades there has been an unwritten understanding that administration costs should not exceed 10% of total spending by medical schemes. This unofficial maximum has been respected, but as annual contributions and spending on health services have increased at rates far exceeding inflation, administration costs have also increased rapidly in real terms.

Managed care mainly relates to chronic medicine management and pre-hospital authorisation. Managed care activities are usually undertaken by organisations owned by a 'parent' company that also owns medical scheme administration companies. For example, Metropolitan Holdings Limited owns both Qualsa (a managed care organisation) and Metropolitan Health Group (the third largest medical scheme administrator). So Metropolitan Holdings Ltd (and other large medical scheme administrators) can extract administration fees **and** managed care fees from medical schemes.

Brokers are a relatively new phenomenon in South Africa. They persuade individuals interested in medical scheme cover to join certain schemes. Brokers' commissions are paid by the scheme in line with the number of new members secured. As the overall number of medical scheme members has been fairly static over the past decade, much of brokers' work has involved switching members from one scheme to another. Until 2004 when regulation was introduced to cap broker fees, schemes and their administrators incentivised brokers to favour their scheme by offering high commissions.

In sum, medical schemes in South Africa are faced with uncontrolled expenditure increases. Even though there has been some respite in the last few years, historical experience shows that this tends to be short lived (see *Figure 12*). Efforts to regulate medical schemes and private health care providers seem to have been ineffective.

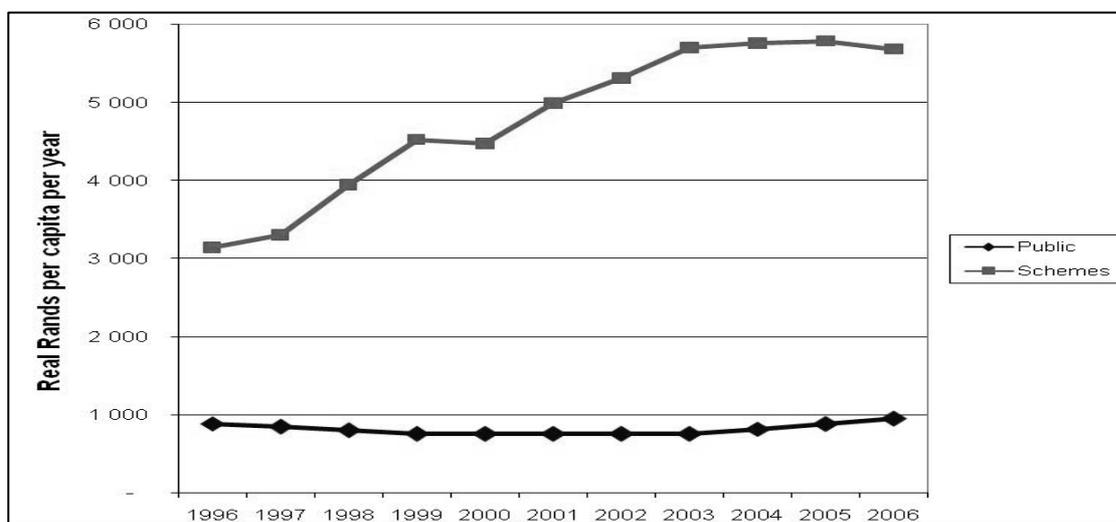
4.3 The private sector and the overall health system

What happens in the private health sector in a particular country inevitably impacts on that country's public health sector (Tuohy et al, 2004), as the South African context clearly illustrates. For example, in the 1990s when medical schemes were deregulated and open schemes were allowed to exclude high-risk individuals from membership and engage in risk-rating, there was extensive 'cream-skimming' resulting in the public health sector bearing the burden of caring for South Africans with the greatest risk of ill health. Similarly, the design of medical scheme benefit packages impacts considerably on the public health system; when medical scheme members' benefits are 'used up' in a particular year, members then often turn to the public health sector for specialist and hospital-based care.

One of the greatest challenges facing the South African health system is the relative sizes of the public and private sectors, in terms of the amount of resources (financial and human) and the population size served. *Figure 14* shows the difference in per capita spending between the public and private sectors, and the growth in this difference in recent years. While real per capita government spending on health care declined in the late 1990s and only returned to its 1996 levels by 2005, there was a concurrent rapid increase in real medical scheme spending (see also *Figure 12*). In 1996, per capita spending by medical schemes was three times more than government spending; by 2006 it was almost six times more.

As indicated in *Figure 7*, most health professionals (except enrolled nurses) work in the private sector. The relative distribution of health professionals between the public and private health sectors continues to move in favour of the private sector (e.g. from 40% of doctors in the private sector in the early 1980s, over 60% by 1990, and about 70% currently). Although there has been no systematic research to date on the reasons for this movement, there are both push and pull factors. In terms of push factors, a growing perception of poor conditions of service in the public health sector has been critical, not only in relation to salaries but also workload, the lack of available equipment and supplies seen as important for the provision of quality health care, and whether or not policy makers and managers are seen to provide a supportive working environment (Gilson et al, 2005). A vicious cycle is created: as more health professionals leave the public sector, and vacant posts are not filled due to funding constraints (see *Figure 14*), so the relative workload per health worker increases which then 'pushes' more and more professionals into the private sector.

Figure 14: Trends in real per capita spending in the public sector and medical schemes, 1996–2006 (2000 base year)

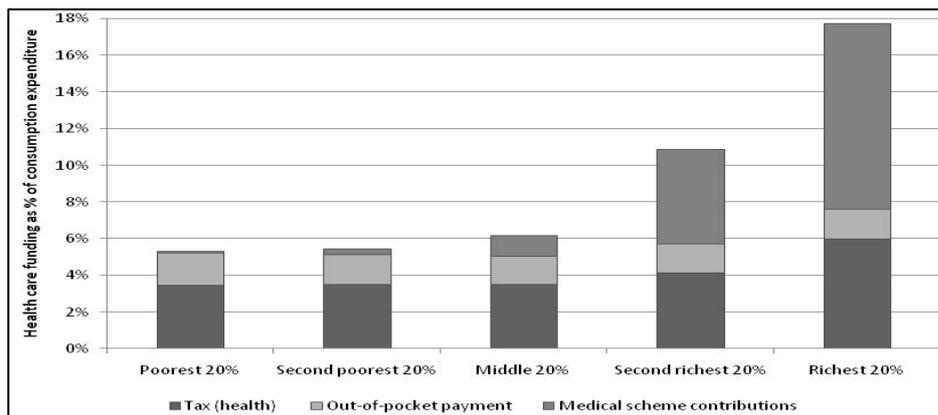


Source: McIntyre and van den Heever, 2007

However, 'pull' factors are also critical. In particular, the far better resourced medical schemes (with 44% of all funds for health care in South Africa in 2007 serving only 15% of the population), combined with the third-party funder and fee-for-service mechanisms, provides a more conducive work environment than the public sector (McIntyre et al, 2007). Further, when providers are paid on a fee-for-service basis (creating an incentive to provide more and higher levels of service), have relative freedom in setting their fee levels and where history shows that there is limited ability to control supplier-induced demand, the 'pull' to this sector is strong.

The impact of this public-private mix can be clearly seen when one considers the financing and benefit incidence patterns in the overall health system. Financing incidence indicates which socio-economic groups bear what part of the burden of funding health care. Health care financing is usually judged according to the principle of contributing according to one's ability-to-pay (or income level). Thus 'progressivity' (i.e. higher income groups contribute a larger percentage of their income than lower income groups) is seen as good. *Figure 15* shows that health care financing in South Africa can be described as very progressive. However, and inevitably, the element of health care financing that most contributes to this 'progressivity' is that of medical schemes, whose funds only benefit scheme members. The more fundamental principle, however, is not honoured: while the highest income groups certainly bear the heaviest financing burden, their medical scheme contributions do not result in income cross-subsidisation in the whole health system.

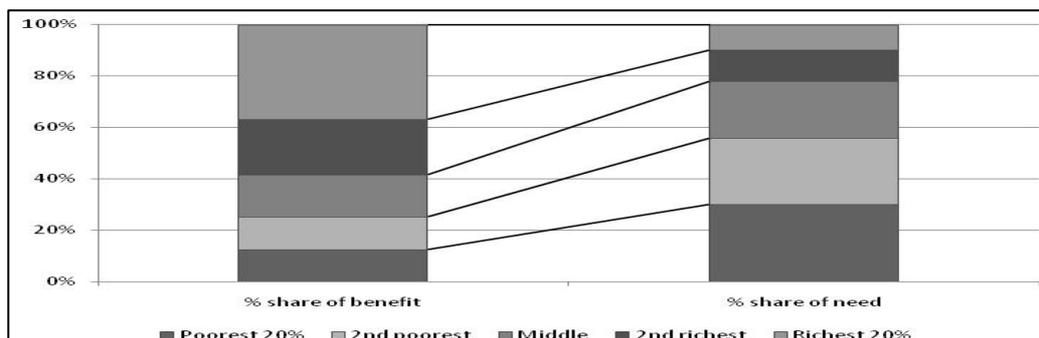
Figure 15: Incidence of types of health care funding in South Africa, 2005/6



Source: Ataguba and McIntyre, 2009

Benefit incidence indicates what benefit different socio-economic groups get from using health services, and is normally assessed in terms of individuals benefiting from health care according to their need for care (not their ability-to-pay). While a definition of need is not universally agreed, the measure used most often internationally is self-assessed health status collected through household surveys; *Figure 16* compares the relative share of health care benefits for different socio-economic groups with this measure of need. It shows that poorer groups bear the heaviest burden of ill-health, but the distribution of benefits of using health services in South Africa is not in line with the distribution of the need for health care.

Figure 16: The incidence of health care benefits in South Africa



Source: Ataguba and McIntyre, 2009

These financing and benefit incidence patterns suggest there are problems in relation to income and risk cross-subsidies in the overall South African health system. Although South Africa has a 'progressive' health system, because the high spenders in the medical schemes are in essence spending on their own health, the more fundamental principle of cross subsidy from rich to poor is not honoured. Interestingly within medical schemes as *Figure 2* shows there are 'reverse' income cross-subsidies since the lower-income members of schemes contribute a higher proportion of their incomes than richer members. There are also 'reverse' risk cross-subsidies in the overall health system in that those in greatest need of health care receive the lowest share of benefits from using health services.

4.4 Recent efforts to regulate the private health sector

The preceding sections have highlighted that the private health sector faces serious challenges, and that the way the private and public health sectors have developed (or in the case of the public sector, been underdeveloped) has created equally serious challenges in the overall health system. This section considers the extent to which regulations have been put in place to address these challenges.

A range of regulations govern the private health sector in South Africa, but these are quite fragmented (contained in a myriad of different pieces of legislation and with different bodies responsible for regulation development and implementation) and sometimes contradictory. A relatively comprehensive overview of private sector regulation is provided elsewhere (McIntyre et al, 2007), so this section only highlights some of the key gaps and challenges.

The key focus of private health sector regulation has been on protecting the public in relation to quality of health services and products. In addition, the most extensive regulations relate to the production and sale of pharmaceutical products, and to some extent of health professionals' issues, with relatively little regulation of health facilities and equipment.

Very few regulations and legislation directly influence the quantity and distribution of health care providers in South Africa. In terms of the National Health Act, which came into effect in mid-2004, the Director-General (DG) of the national DoH is responsible for issuing licenses or a 'Certificate of Need' for all private hospitals, private practices and 'prescribed health technology' or 'high-tech' equipment, both for existing services and for proposed future services. All facilities and practices that existed when the Act was promulgated had to apply for the certificate within 24 months. Before issuing or renewing a certificate, the DG must consider the quality of services provided and the

need to promote an equitable distribution and rationalisation of health services and health care resources,... the need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers.

The Certificate of Need is a potentially powerful mechanism to influence the quantity, distribution and quality of health services, and a way to address potentially perverse incentives (e.g. shareholding in private hospitals by doctors) that could contribute to excessive expenditure. The Certificate of Need legislation is highly controversial, with health professional associations and private hospital groups vociferously opposing it, so it has not yet been implemented.

Regulation of the prices of health services is very limited, with only price regulation of medicines in place (which controls pharmaceutical product prices, the fees charged by wholesalers and distributors and dispensing fees). Other aspects of the legislation that can impact on medicine prices and expenditure include generic substitution by pharmacists, compulsory licensing and parallel importation.

The National Health Act makes provision for a NHRPL, which recommends the fees to be charged for different health services provided by private practitioners or private hospitals. However, the Act states that the NHRPL

may be used – (i) by a medical scheme as a reference to determine its own benefits; and (ii) by health establishments, health care providers or health workers in the private health sector as a reference to determine their own fees, but which are not mandatory.

In terms of medical schemes, they were initially regulated to have community-rated contributions and were based on social solidarity principles, but were deregulated in the late 1980s and allowed to risk-rate contributions from 1993 to 1999. A comprehensive regulatory framework was introduced with the promulgation of the *Medical Schemes Act of 1998* and associated regulations, which came into effect on 1 January 2000. The Act aimed to ensure that each scheme, and individual benefit options in that scheme, is financially sound and sustainable. It also aimed to protect medical schemes from adverse selection (where those at higher risk are more likely to take out insurance) and to put some mechanisms in place to protect the public from 'cream-skimming' by schemes (whereby the scheme tries to exclude high risk individuals and attract the young and healthy). The Act also prescribes that contributions must be community-rated. Regulations ensure that every scheme has to provide cover for a 'prescribed minimum benefit package', which includes health services that could impose catastrophic costs on members. While a more comprehensive regulatory

framework governing medical schemes' operations and a strong regulatory authority (the CMS) is now in place, *Figure 12* raises serious questions about whether these regulatory interventions address the key challenges facing medical schemes.

5. National Health Insurance policy developments and debates

There is currently considerable debate about the proposed introduction of national health insurance (NHI) in South Africa, which could have considerable implications for the private health sector. This has followed from the decision at the 2007 policy conference of the ruling African National Congress (ANC) to introduce a NHI. However, this is not a new debate; since the late 1980s a number of proposals have been made to introduce mandatory health insurance. This section provides a brief historical overview of these debates and then critically considers the current proposals on mandatory health insurance.

5.1 Overview of historical debates on mandatory health insurance in South Africa

This section provides a brief overview of the specific proposals for developing a mandatory health insurance system, put forward as part of official policy processes since 1994. These are summarised in chronological order in *Table 4*, and include proposals made by:

- the 1994 Health Care Finance Committee (DoH, 1994);
- the 1995 Committee of Inquiry into a National Health Insurance System (SA, 1995);
- the 1997 SHI Working Group set up by the national Department of Health (DoH, 1997);
- the Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa (which included proposals on the health sector and other social security mechanisms) (Department of Social Development, 2002); and
- the Ministerial Task Team which considered which, if any, of the Taylor Committee proposals to take forward (Ministerial Task Team, 2004).

The overview is summarised using a Kutzin (2001) framework, focusing on the key functions of a health care financing system, namely:

- **revenue collection:** the sources of funds, their structure, and how they are collected;
- **pooling of funds:** the size and composition (in terms of which socio-economic groups) of the population covered by a particular pool;
- **purchasing:** the transfer of pooled resources to health service providers so that appropriate and efficient services are available to the population (i.e. the benefit package and the provider reimbursement mechanisms); and
- **provision** of health services.

Table 4: Overview of proposals for mandatory health insurance in South Africa

Features	Health Care Finance Committee (1994)* (similar to ANC plan)	Committee of Inquiry (1995)	Department of Health SHI Working Group (1997)	Taylor Committee of Inquiry into comprehensive social security (2002)	Ministerial Task Team for implementing SHI (2002)
Revenue collection: Sources of funds; contribution mechanisms; & collecting organisation(s)	All formal sector employees (employers pay part contribution); community rating Private insurers could be intermediaries for SHI	All formal sector employees (employers pay part contribution); community rating Choice between state-sponsored SHI fund and private insurers	Formal sector employees over income tax threshold but not medical scheme members (employers share contribution); community rating Separate state hospital fund, or 'opt out' for private insurer	Mandatory for formal sector employees over income tax threshold via medical schemes and voluntary for low income, informal sector via state sponsored scheme – community rating Others through dedicated payroll tax Ultimately all to make income-related contributions	Mandatory SHI tax (as part of a composite Social Security tax) – all taxpayers Voluntary community-rated contributions to medical scheme (possibly make mandatory later)
Pooling of funds: Coverage (risk pool); allocation mechanisms	Contributors and their dependants Risk-equalisation between individual insurers	Contributors and their dependants Risk equalisation between state-sponsored fund and individual private insurers for compulsory benefit package	Contributors and their dependants No risk-equalisation between state fund and private insurers. Allocation from state fund to hospitals through government budget process.	Universal Risk-equalisation between state-sponsored scheme and individual private insurers for uniform minimum benefit package	Universal for the basic benefit package, but contributors and dependents for 'top-up' Risk-adjusted subsidy to public sector & schemes for basic benefit package
Purchasing: Benefit package; provider payment	Comprehensive services (primary care and hospital services) Collectively negotiating provider payment rates	Hospital services Payment rates set at cost of service in a public hospital	Public hospital services Unspecified for private insurers Budget for state fund Fee-for-service for private insurers	All eligible for minimum package (primary care, chronic illness and hospital care) Budgets and salaries for public facilities, capitation for private PHC via state scheme, unspecified for medical schemes	Basic benefit package of primary care plus existing PMBs No specific changes in provider payment from what currently exists
Provision	Mainly public, but some role for private providers in primary care	Choice of provider, with competition between private and public hospitals	Public hospitals only for state fund Choice for privately insured	Public facilities for non-contributors 'Differentiated amenities' / 'private wards' in public hospitals and private PHC providers for state scheme Choice for medical scheme members	Public facilities for non-contributors and low-income payers of SHI tax Choice for medical scheme members

**The Health Care Finance Committee considered three different potential SHI designs. The design that was supported by this Committee is presented in this table.*

Source: McIntyre et al, 2007

5.1.1 Revenue collection

All previous proposals put forward in South Africa suggested that mandatory health insurance contributions (or a dedicated payroll tax for health care), which should be shared between employees and employers, should be introduced to complement general tax resources. While some proposals suggested that all formal sector employees should make mandatory insurance contributions, the focus later switched to those required to pay income tax. Some proposals did not specify if contributions should be proportional (where each contributor pays the same percentage) or progressive (where those with a higher salary pay a higher percentage of their salary than those with lower salaries). Those that did refer to a contribution structure recommended a proportional structure.

The 1995 Committee of Inquiry (DoH, 1995) was the first to propose the reform of tax deductions for medical scheme contributions, which would increase general tax revenue. The Taylor Committee later recommended that tax deductions on medical scheme contributions be completely removed. They proposed that instead every South African should receive the same direct subsidy, paid from general tax revenue, towards covering their health care requirements. This subsidy would be set at a level that covers the full costs of a basic package of health services in the public sector (i.e. the subsidy would not be subject to the vagaries of uncontrolled expenditure increases experienced in the private health sector). This subsidy would either be paid to public sector facilities or to individuals' insurance schemes.

All the proposals envisaged that medical schemes would continue to play a role in a future mandatory health insurance. In particular, medical schemes in most cases were seen as being financial intermediaries for a mandatory insurance and as offering 'top-up' packages to cover services outside of the mandatory benefit package. Almost all proposals recommended establishing a 'state-sponsored' scheme in addition to the existing medical schemes. The state-sponsored scheme would pay close attention to achieving value for money for members and provide an alternative to existing medical schemes, which as illustrated above have been unable to contain the rapid expenditure increases that plague them.

5.1.2 Fund pooling

Most debate on mandatory health insurance has focussed on fund pooling, particularly in recent years. While early proposals explicitly argued that mandatory insurance should only cover those who made insurance contributions and their dependants (i.e. a social health insurance or SHI), more recent proposals have argued that the ultimate objective should be universal coverage (i.e. a NHI). However, even these recent proposals envisaged retaining a two-tier system whereby formal sector workers belong to a health insurance scheme and others receive their care from tax-funded public sector health services. Recent proposals envisaged a single pool of funds which incorporated mandatory contributions and funds from general tax revenue. Allocations would be made from this pool to individual insurance schemes on the basis of a risk-adjusted capitation (i.e. an amount of money per capita or per insurance beneficiary, based on the likelihood, or risk, of that scheme's beneficiaries requiring health care, which is judged from indicators of risk, such as age, gender, and the presence of chronic disease). A risk-adjusted capitation amount would also be paid from the single pool for all who are not contributors to the mandatory insurance, and would then be allocated by means of budgets to individual public sector health facilities.

5.1.3 Purchasing and provision

Most proposals have supported a relatively comprehensive benefit package, except those put forward in the mid-1990s which suggested excluding primary health care

services from the package, since free primary health care services in the public sector had just been made available. However, most proposals envisaged that different providers could be used by mandatory insurance contributors and non-contributors, with contributors having freedom of choice of providers and non-contributors being restricted to public sector providers.

Very few proposals made explicit recommendations on how providers should be paid. However, all the proposals recognised that it was important to address problems related to fee-for-service payments. Several proposals recommended capitation to pay GPs and integrated primary care providers in the private sector.

5.2 Current proposals for national health insurance

After the decision at the ANC Policy Conference in December 2007 to introduce a NHI, a task team of ANC members was established to develop detailed proposals on the form an NHI should take. This task team submitted its report to the ANC National Executive Committee's Subcommittee on Education and Health. The Minister of Health appointed a Ministerial Advisory Committee in late 2009 to help develop a formal government NHI policy proposal, which would be made available for public comment.

At the time of writing, the ANC Task Team report has not been made public nor has any official government policy proposal been released. It is, therefore, difficult to indicate exactly what form of NHI is envisaged. However, in this section we outline the broad principles and expected design of the proposed NHI, based on information in the public domain, largely through media reports. Differences to earlier mandatory health insurance proposals will be highlighted, as well as views of key 'stakeholders' that have been presented in public forums (e.g. at health-related conferences, in press reports, in parliamentary debates, etc).

5.2.1 Principles underlying the proposed NHI

The proposed NHI is seen as a means to achieve universal financial risk protection and health service access and address health system inequities. These objectives were outlined by the Minister of Health and Deputy Minister of Health in the debate on the health budget in the National Assembly (parliament) on 30 June 2009:

NHI is a system of universal healthcare coverage where every citizen is covered by healthcare insurance, rich or poor, employed or unemployed, young or old, sick or very healthy, black or white.

Dr Aaron Motsoaledi, Minister of Health

It is time to implement such a system [NHI], which is based on access to health services that are provided in a manner that effectively addresses the inequities of the past and also ensures that there is a unified national health system that accords our citizens sufficient financial risk protection from catastrophic health-related expenditures and improves the health outcomes of the population.

Dr M Sefularo, Deputy-Minister of Health

The proposed NHI differs from previous proposals in that it aims to achieve a unified and integrated system from which all South Africans can benefit, whether or not they make mandatory insurance contributions. The language of universality represents a distinct departure from the earlier proposals which focused more on a SHI structure with different benefit packages (particularly in terms of providers that could be used) according to insurance contribution status. This principle is reflected as follows:

There should be universal access to health services that meet established quality standards so that everyone is able to use health services according to the need for health care and not on the basis of ability to pay.

ANC, 2009

5.2.2 Revenue collection in the proposed NHI

The proposed NHI would be funded by a combination of general tax revenue and mandatory insurance contributions. There have been calls for a substantial increase in the allocations from general tax revenue to the health sector. General tax revenue would therefore be the core component of NHI funding.

The commitment to social solidarity in the South African health system means a mandatory contribution by South Africans to funding health care according to their ability to pay. Given the massive income inequalities, progressive funding mechanisms must be used (i.e. the rich should contribute a higher percentage of their income to funding health services than the poor) and the government contributes for the indigent.

ANC, 2009

This reflects that allocations from general tax revenue are effectively regarded as contributions to the NHI made on behalf of everyone who is not regarded as being able to contribute directly themselves. An issue of relevance to revenue collections is that tax deductions for medical scheme contributions would be removed. This would increase total tax revenue which could facilitate additional allocations from tax revenue to the health sector. It has also been stated that no out-of-pocket payments would be required for services covered by the NHI.

While many of these aspects of the proposed NHI are similar to earlier proposals, the two areas of difference are:

- Recognition that general tax revenue will be a core funding source for the NHI, that tax revenue allocations need to be increased, and that mandatory health insurance contributions will be complementary to general tax revenue. Some earlier proposals (such as the Taylor Committee) in fact stated that general tax funding should be phased out and that mandatory health insurance would over time become the sole funding mechanism (see *Figure 17*).
- An explicit commitment to services being free at the point of service and not to rely on out-of-pocket payments as a funding source.

5.2.3 Fund pooling in the proposed NHI

The proposed NHI would pool all allocations from general tax revenue and mandatory health insurance contributions in a NHI Fund. These funds would then be used to purchase a uniform package of services for all South Africans.

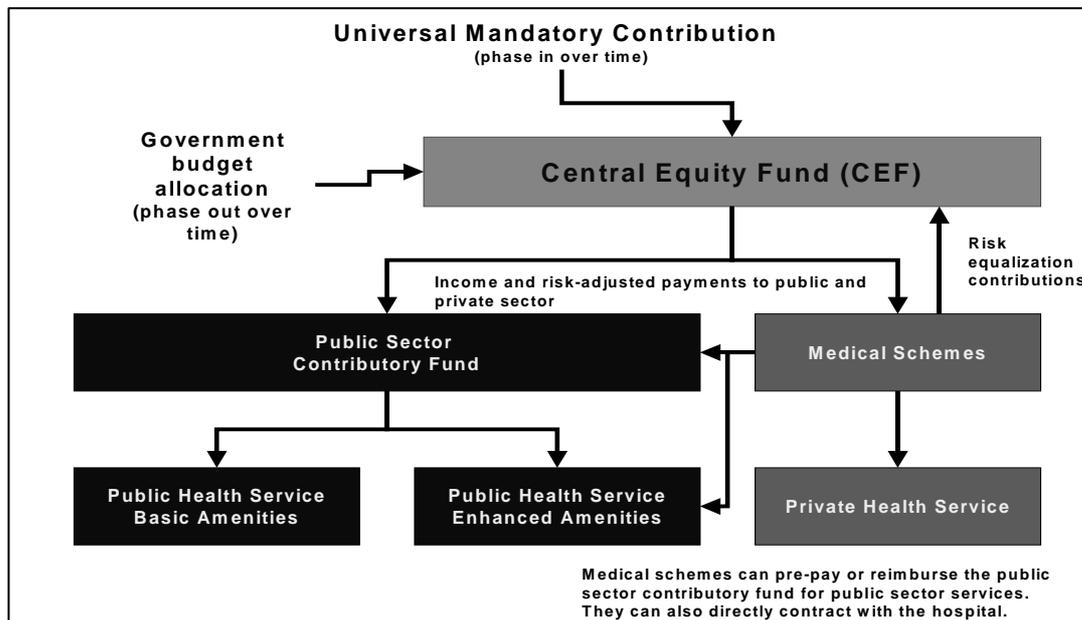
The main sources of funding for the NHI will be allocations from general tax revenue with a progressive increase of the public health sector budget over five years and a small mandatory health insurance contribution. All of these funds will be combined into a single NHI Fund, from which all services covered by the NHI will be funded.

ANC, 2009

This proposal is quite different to earlier proposals. Some earlier proposals recommended a complete separation of tax funding and the mandatory insurance contributions; the mandatory health insurance revenue would be used to only benefit those who contributed through this mechanism, while general tax funds would be used to purchase services for the rest of the population. Other proposals (from the Taylor Committee and the 2002 Ministerial Task Team) envisaged a single pool of funds, but allocated to individual medical schemes (i.e. there would still be an element of fragmentation, particularly in relation to purchasing). *Figure 17* illustrates

what the Taylor Committee had in mind in terms of the flow of funds under their 'universal' system.

Figure 17: Funding flows envisaged by Taylor Committee



Source: DoH, 2002

The main difference between the current proposals and those of the Taylor Committee and Ministry of Health Task Team is that, although medical schemes would still exist under both current and previous proposals, under the current proposals no funds would be transferred from the general tax and mandatory insurance contribution pool to individual schemes. Under the current proposals, individuals may choose to have medical scheme cover, but the full contribution to such schemes would be over and above their mandatory NHI contribution.

5.2.4 Purchasing and provision in the proposed NHI

The greatest difference between current and previous proposals on mandatory health insurance is on purchasing and provision of services. The NHI proposal envisages that geographical structures (e.g. provincial, regional and district health authorities) would purchase health services on behalf of the entire population resident in their area with, in effect, a single purchaser of services in each area.

Purchasing refers to the transfer of financial resources to both private and public health service. The NHI through its sub-national levels will assess the specific health care needs of the community served, decide on what type and quantity and quality of health services are required to meet these needs, and which health care providers should provide these services to ensure that appropriate services are available to the population.

ANC, 2009

The benefit package (although yet to be specified in detail) would be relatively comprehensive, i.e. it would cover a wide range of outpatient and inpatient services from the primary care level through to tertiary levels. Although some of the earlier proposals also included comprehensive benefit packages, the key difference is that in the earlier proposals, clear distinctions were made about which health care providers could be used based on whether or not a person had made health insurance contributions. As indicated in *Figure 17*, the Taylor Committee proposed that contributors would access private providers (or public providers if they chose to, but with 'enhanced amenities') whereas non-contributors would only be permitted to

use public sector facilities. The current proposals indicate that services would be purchased from both public and private accredited providers, and all South Africans would have a choice of provider.

There will be a comprehensive package of services that includes primary health care services as well as hospital inpatient and outpatient care. People will be expected to follow the appropriate referral route to ensure effective gate-keeping as at the primary health care level before referrals to specialists and hospital-based care when necessary. This will ensure that resources are used efficiently and appropriately. People will have choices of where to obtain care ... Health care will be purchased from either public or private health care providers which have been accredited by the NHI.

ANC, 2009

There will also be a move away from fee-for-service reimbursement and towards capitation payment for services covered by the NHI. Although the Taylor Committee did recommend capitation payments for primary care services, this was restricted to those covered by the 'state-sponsored' medical scheme and not necessarily a universal change.

The main provider mechanism will be capitation payments (i.e. a set amount per person per year) in its various forms. The payment arrangements will be structured to ensure that both providers and users of services are less inclined to overuse or over service patients and hence control spiralling of costs.

ANC, 2009

In relation to provision, it is not clear exactly how the inclusion of both public and private providers in the NHI will operate. Some information on accreditation criteria and related matters is available:

Providers will be accredited on the basis of their ability to provide services of acceptable quality, willingness to accept payment levels affordable to the NHI, and the need for such providers within a particular area ... At the primary care level, existing private general practitioners (GPs) can be accredited if they work in group practices, which include primary health care nurses and a range of allied health professionals. Similarly public and private hospitals at various levels will be accredited to provide NHI services. People can then choose between accredited providers in their area.

ANC, 2009

It is clear is that in the preparation for implementation of the NHI, a very large emphasis will be placed on rebuilding the public health sector, both in relation to quality service provision capacity and improved facility management ... it has been generally accepted that revitalisation of all hospitals, improvement of the remuneration packages of the health care workers and transformation and capacity building of management is a pre-requisite for the NHI. This means that there is need for tremendous investment into the public health services.

Mkhize, 2009

Universal access to health services can only be achieved through a simultaneous and two-pronged approach. First, significantly strengthen the public sector so that it becomes the provider of first choice. Second, design mechanisms for ensuring that scarce and critical health service resources in both public and private sector are shared and optimally used by all to maximise social value.

ANC, 2009a

5.2.5 Stakeholder views on the proposed NHI

Having outlined the key principles and design features of the proposed NHI, based on the limited information available, it is useful to consider the views of 'key stakeholders' on these proposals. Before doing so, it is important to note two caveats. Firstly, given that the full, detailed proposals on the NHI have yet to be made public, the stakeholder views presented here cannot be regarded as fully informed. Some stakeholders explicitly stated that they will reserve judgement on the NHI until the detailed proposals are in the public domain. Nevertheless, this section will provide some insights into the concerns of stakeholders who have commented publicly on the proposed NHI. Secondly, there are few mechanisms for gauging the views of the general public — the main intended beneficiaries of the NHI. Thus, the review of stakeholder views does not reflect the views of possibly the most important stakeholder group; this gap must be addressed in future discussions about the NHI by seeking ways to facilitate the public to air their views and preferences.

The main categories of stakeholders whose views are reviewed here include:

- **political parties**, particularly the official opposition Democratic Alliance, but also other parties which have publicly expressed a view on the NHI;
- **government departments**, particularly the DoH and the National Treasury;
- **medical schemes** (Discovery is specifically referred to here as it is the biggest medical scheme and more importantly, it is one of the few schemes or scheme administrators to have publicly commented on NHI; indeed, Discovery has commented widely on the proposal);
- **private providers**, particularly private hospitals and private doctors; and
- **civil society organisations** including employer groups, trade unions and health-related non-governmental organisations (NGOs).

At this stage, very few stakeholders have expressed either full support or complete opposition to the proposed NHI. Most stakeholders have expressed broad support for an NHI, but raised specific concerns. *Table 5* summarises the main concerns raised by stakeholders and/or the main anticipated benefits of the NHI, based on available information. Further details of stakeholder positions are presented after the table.

Table 5: Summary of stakeholder views on proposed NHI

Stakeholder	Main concerns/ anticipated benefits
Political parties	
Democratic Alliance (DA) (official opposition)	Agree that change is needed and that equity is an important goal, with focus on all having access to 'decent health care', but explicitly opposed to NHI. Propose major focus should be on dealing with problems in public sector, which they believe are largely related to poor management, and would like to see a greater role for the private sector. They have expressed concern that the government lacks the capacity to appropriately manage the NHI and they NHI will: <ul style="list-style-type: none"> • adversely affect the private health sector; • raise the costs of the health system; • waste resources on administration; and • impose a greater tax burden.
Independent Democrats	Explicitly supports NHI and sees it as a mechanism to address health system inequities and make more funds available for public sector services. They are concerned that the proposed pace of change is too rapid, and will therefore monitor the proposals for inefficiencies.
Government departments	
DoH	Put forward a proposal for SHI in 2008, with Government Employees Medical Scheme (GEMS) being opened to those outside the civil service. Current position, expressed in a policy proposal, not yet available.

Stakeholder	Main concerns/ anticipated benefits
National Treasury	No publicly expressed view on the NHI. Noted that it is critical to have accurate actuarial costing of NHI.
Medical schemes	
BHF	Stated support for objectives of NHI, but propose incremental change building on both the public and private sectors, so that access is brought up to medical scheme level. Protecting the constitutional rights of medical scheme members and medical schemes must be a key component of NHI.
Discovery	Stated support for objectives of NHI, but propose it should focus on addressing the problems in the public sector, as the private sector is effective, high quality and self-sustaining. They are concerned that the NHI not overburden employed tax payers.
Private providers	
Hospital Association of South Africa (HASA)	Supports principle of universal access, but published HASA research suggests serious reservations about key elements of NHI proposals.
South African Medical Association (SAMA)	Explicit resolution of SAMA National Council endorses a system of universal access, and believes the public and private sectors can contribute to achieving this objective.
Civil society groups	
Business Unity South Africa	Supportive of NHI objectives, but emphasises the key role of private health sector, and expressed concerned that proposed pace of change is too rapid.
Trade unions	Strongly supportive of NHI and see it as mechanism for transforming the health system (see details below).
Treatment Action Campaign	Don't explicitly support NHI, but support fundamental health system change (both public and private sectors). They have expressed concern about lack of public engagement to date.

The only political parties (other than the ANC) that have publicly expressed a view on the NHI are the official opposition (DA), who oppose the NHI, and the Independent Democrats who support the NHI, as outlined in *Box 1*.

Box 1: Views of political parties on NHI

Democratic Alliance

We need to work towards a more equal healthcare system, narrowing the level of service between the rich and the poor ... the DA — as many other important role-players in the industry — is opposed to the ANC's proposed National Health Insurance plan.

Theuns Botha, Minister of Health of Western Cape, *Budget Speech*, 23 June 2009

Reform of our health system must aim at correcting the failures in public health and spreading wider the successes in private health. Unfortunately the ANC's proposed National Health Insurance (NHI), which is estimated to cost R100 billion a year, would do neither. It would deepen the failure of public health and reduce the benefits of private health. It would spend a bigger proportion of funds on bureaucrats rather than doctors ... An ANC task team refers to it as a 'mechanism for cementing social solidarity in the health system'. It is of course a mechanism for destroying the health system. The NHI will take those most responsible for crippling our present public health — the inept state bureaucrats — and give them enormously more power over the whole health system. It is difficult to avoid the conclusion that plans for the NHI are driven more by ideology than concern for the welfare of the South African people. Hurting the middle class seems more important than helping the poor (and of course hurting the middle classes invariably means making the poor poorer) ... The DA takes a different approach based on the simple aim of finding the most just, efficient and economic system of providing every single South African with decent health care. We do not want revolutionary change. We just want to fix what is broken and to extend what is working well. It

is extremely important to realise that the failure of our public health sector is not just a matter of funding ... Bad management is the primary reason for the decline of our public health. ... The DA wants a fruitful co-operation between the private and public health sectors, rather than the strained relations that now exist because of ANC's attitudes. The private sector could help provide managerial and administrative support to the public sector. It could help with the training of medical interns. There could be a requirement that, in order to stay registered, private doctors would have to work a certain number of hours in the public sector each year. There could be more private wards in public hospitals, to the benefit of both sectors and their patients. ... The DA does not want to harm or curtail the private health sector. We want to encourage it and work with it and use all of its skills and advantages to help improve our public health, and so to improve the health of all South Africans.

Zille, 2009

Independent Democrats

The Independent Democrats believes not only in health care for all, but in quality health care for all. It is clear that more money needs to be directed at improving the desperate state of many of our country's hospitals and clinics. This could be achieved through the introduction of a National Health Insurance Scheme with the money being directed at improving the public health care sector.

ID, 2009a

Inequalities in healthcare have always been a major concern to us and this is why we have advocated for National Health Insurance ... Our nation must understand that uniting to address the massive inequalities in our healthcare system is unavoidable and involves a cost to taxpayers that is offset by vast moral benefits. ... Government must avoid sacrificing efficiency and attention to detail in its rush to overhaul healthcare – it is crucial that this mammoth task is performed carefully and with the best interests of our people at heart. ... The Independent Democrats will be following the budgetary implications of the implementation of the plan very closely to ensure that there is no unnecessary wastage of public funds. The public participation process will also be crucial to its success.

Haniff Hoosen, ID Spokesperson on Health, *Health Budget Debate*, National Assembly (ID, 2009b)

The position of key government departments is unclear at this point. In 2008, the DoH developed a policy proposal for a SHI, along the lines of the 2002 Ministerial Task Team. In particular, it recommended that GEMS should be used as the vehicle for the 'state-sponsored scheme'. The current position of the DoH will become clearer once the Minister of Health submits an NHI policy proposal to cabinet. The National Treasury, which has been influential in previous policy debates on mandatory health insurance in South Africa (McIntyre et al, 2003), has also not publicly indicated its views. However, Treasury is clearly concerned about the resource requirements of the NHI and the implications from a tax perspective, as shown by its commissioning of an actuarial costing of the NHI.

The medical schemes sector has indicated broad support for the objectives of a NHI. The stated views of the BHF — a representative association of medical schemes, and the largest scheme, Discovery, are captured in *Box 2*. The reason for including the views of an individual scheme as well as those of BHF is that Discovery withdrew from BHF in late 2008, reportedly over differences of opinion on the proposed NHI. Medical scheme stakeholders explicitly state that they support the objectives of a NHI, as opposed to stating support for the proposed NHI, suggests that the envisaged structure for the NHI does not necessarily meet with their approval. The statements from the schemes' sector highlight their preference for medical schemes to play a key role in a future NHI, potentially along the lines of the earlier mandatory insurance proposals where they would be the financing intermediaries for an NHI.

Box 2: Views of medical schemes on NHI

Board of Healthcare Funders

BHF strongly supports the objectives of NHI defined as the provision of universal access to a defined range of healthcare services for all South Africans at an affordable cost. The achievement of an NHI system is a process and not an event. The policy framework for achieving an NHI must therefore be a progressive and incremental one, which is based on the realities of the South African economy, and the South African healthcare system. This process should build on and expand the existing assets of both the public and private South African healthcare systems. We strongly support increased allocation of government funds to the public health sector so that it becomes a substantial and major backbone for rendering health services in an NHI environment. The NHI system should be built by integrating the existing public and medical scheme financing mechanisms into a workable system that achieves the goals of the NHI. In the development and implementation of the NHI model in South Africa, careful consideration must be given to the Constitutional rights of the medical schemes members. The NHI system should work on bringing levels of access up to those enjoyed by the currently insured population and not inadvertently reduce the levels of access of the latter. What the medical schemes have been providing to its membership in terms of access, quality and human dignity issues — must be maintained or preferably improved on even in an NHI environment. The current medical scheme system is a precious asset that is highly valued by its current membership, and should be a very valuable and critical component of any proposed NHI system.

BHF, 2009

Discovery

The key objective of the proposed NHI system appears to be to provide universal access for all South Africans, to a decent package of healthcare benefits. We strongly support this objective. To achieve this will require a focus on tackling the severe and ever worsening problems of our public hospital system. This is the backbone of South Africa's healthcare system, and fixing it must surely be the highest priority for government over the next five years. The most fundamental problem ailing our healthcare system is the failure of the public healthcare sector to meet the healthcare needs of our country's citizens, as well as its failure to use our scarce public funding efficiently and appropriately in order to improve accessibility, quality of care and health outcomes. The upliftment of standards in South Africa's public sector will go a long way to expanding access and delivering quality healthcare to the population. ... any new payroll tax (which will be shared between employers and employees) will undoubtedly impact on the cost of employment, and hence on the potential of the economy to create new jobs. It is also not clear that economic realities will allow an NHI system to provide a comprehensive package of benefits to all South Africans. We live with the unfortunate reality of one of the world's highest unemployment rates. This means that a relatively small number of employed tax payers will have to carry the cost of providing the envisaged package of healthcare benefits to the entire population.... South Africa has developed a sophisticated and world class private healthcare system. This is a national asset, and is critical to many key government objectives including those of skills retention and foreign direct investment. Proponents of the NHI seem to see the private health sector as the root of all problems, and many of the proposals seem aimed at damaging private healthcare, rather than improving the public system. Ironically, any weakening of the private sector to attempt to supplement the public sector will result in an increased burden on the public system. ... The fact is, while the private healthcare system can certainly be improved and made more efficient, it is an effective, high quality, self-sustaining system, funded by the voluntary contributions of the public; it needs to be seen as part of the solution.

Dr Jonathan Broomberg, Head of Strategy and Risk Management, Discovery Health

In general, private providers have not made many explicit public statements on the proposed NHI. For example, HASA which represents the private for-profit hospital sector has simply stated:

The Hospital Association of South Africa endorses the principle of universal access to quality healthcare for all South Africans. While most, if not all,

stakeholders support the objective of a National Health Insurance (NHI) system, approaches as to how to implement the system differ.

Hospital Association of South Africa, 2009

This is a very similar approach to that adopted by medical schemes, namely agreeing with the broad objectives, but giving some indication that the specific NHI proposals may not be supported. HASA has produced several documents which review international experience, and which:

- argue that South Africa's levels of unemployment, economic development and income inequality make it unfeasible to achieve a single tier health system;
- estimate that 50% of the entire government budget would be required for a universal system, based on extrapolating medical scheme funding requirements to the whole population, and that NHI is unaffordable; and
- argue that a single pool of funds and single purchaser of health care does not yield better results than multiple pools and purchasers (HASA, 2009; Da Costa et al, 2008).

SAMA, which represents generalist and specialist doctors, is one of the few organisations to have adopted a specific resolution on the NHI (SAMA, 2008):

Noting the move towards National Health Insurance (NHI) for SA, and the internationally-experienced challenges relating to its implementation, resolves that:

- *SAMA reaffirms its endorsement of a system of universal access to healthcare for all South Africans;*
- *SAMA reaffirms the position that Public and Private sectors both add value and must continue to contribute synergistically to the achievement of this objective under the banner of a NHI;*
- *SAMA continues to explore, prepare model/s, present, pilot & co-implement practical, viable ways to achieve these objectives.*

Once again, the objectives of NHI and principle of universal access is supported, but views on specific NHI proposals are not clear. Employer and employee groups have also indicated broad support for the NHI. The business sector has emphasised the important role of the private health sector and indicated concerns about the pace of change envisaged for NHI, as illustrated in the statement by the CEO of Business Unity South Africa (BUSA) in *Box 3*.

Box 3: Views of civil society organisations on NHI

Business Unity South Africa (BUSA)

Business recognises that NHI is a noble objective and a critical commitment of the new administration. It will be a vital milestone towards the eradication of inequities in our healthcare system. However we would like to caution that a reckless and prematurely implemented NHI may delay the achievement of access to quality healthcare. The successful implementation of NHI depends on the state of readiness of delivery in the public sector and a viable funding model. It will not be in anyone's interest to rush through such a critical policy as it needs to be premised on a sustainable funding model. The private [health care] sector, which developed out of a free market economic environment with all the characters of a commercial enterprise, has a critical role to play in contributing to equitable healthcare.

Vilakazi, 2009

National Education, Health and Allied Workers Union (NEHAWU)

NEHAWU and the broader South African public who have endorsed the transformation of the health system as one of the government's priorities, are determined to ensure that the NHI is implemented. This transformation in our health system will ensure that there will be a universal, comprehensive, free national health care system founded on the primary health care approach.

Fikile Majola, General Secretary of NEHAWU

Treatment Action Campaign (TAC) and AIDS Law Project (ALP)

The Treatment Action Campaign (TAC) and AIDS Law Project (ALP) recognise that the resolution of the crisis in public health care is one of a number of key steps integral to laying the groundwork for the introduction of NHI. In our view, NHI — in essence a funding mechanism that seeks to ensure the equitable distribution of human and financial resources — must be built on the foundation of a strong public health system. The aim of an NHI system is to ensure that everyone has access to appropriate quality health care services, regardless of ability to pay. This constitutional requirement is not and cannot be up for debate. Instead, what must be considered is how best to realise the constitutional vision. This calls for government — led by the Department of Health — to initiate and guide a consultation process on policy that leads to and informs legislative reform. The TAC and ALP look forward to constructive engagement on NHI with government and other stakeholders. In so doing, we recognise that the public and private health sectors in South Africa are intertwined. Implicit in the DA's press statement, however, is that the private sector should be left alone. We strongly disagree. Universal access to health care — a defining feature of NHI — cannot be achieved without appropriate regulation of the private sector.

TAC, 2009

Trade unions have been strongly supportive of NHI proposals and indeed contributed to the ANC task team that drafted NHI policy proposals. Although trade unions have not released any documents that explicitly outline their position on NHI, NEHAWU, the COSATU affiliate representing health workers, has particularly come out in support of NHI (see *Box 3*). A key health-related NGO, Treatment Action Campaign (TAC), while not explicitly supporting the proposed NHI, has strongly supported the need for fundamental health system change (see *Box 3*). A key concern of TAC is that there should be greater public debate and opportunities to contribute to determining the final NHI design.

As indicated earlier, there has been little opportunity to gauge the views of the general public on NHI. A national household survey undertaken last year does suggest that South Africans are ready for health system change. There is dissatisfaction with both the public and private health sectors. In relation to the public sector, there are concerns about the quality of public sector services including the nature of patient-provider engagements, cleanliness of facilities and drug availability. With respect to the private sector, there are concerns about the affordability of medical schemes and how the profit motive affects private providers' behaviour. Over 70% of current medical scheme members agreed with the statement: 'I would join a publicly supported health insurance scheme if my monthly contribution was less than for current medical schemes' (McIntyre et al, 2008).

The recent media coverage on the proposed NHI has illustrated that some members of the public, particularly those who currently have privileged access to health care, will strenuously oppose the NHI, as illustrated by this letter to one newspaper:

I absolutely refuse to register with a gatekeeper primary healthcare giver and have some government-appointed idiot tell me or my family where and who I should consult. I have rights under the constitution and I can, within the law, do as I please and consult who I please with my money. We are already heavily taxed and burdened by medical aid costs and now we are expected to hand out more money.

Vernon Edwards, Letter to the Editor

Given that no formal policy proposal on the NHI has been placed in the public domain, it is not surprising that key stakeholders have not expressed very explicit views. Only the DA has expressed outright opposition to the proposed NHI. Most of stakeholders have expressed support for the objectives of the NHI, but it appears that there will be considerable differences in views on how these objectives can be

achieved. There is unanimity that it will be critical to address the challenges facing the public health sector. A key area of debate is the future role of the private health sector (both medical schemes and private providers), with some arguing that the private sector should be 'left alone' and others indicating that there are also challenges in the private sector which should be addressed during the process of health system transformation proposed under the ambit of NHI.

Those with a substantial commercial stake in health care funding and provision and those with privileged access to health services are expected to oppose changes that would threaten these interests. Across the range of stakeholders, some of the key concerns about the proposed NHI include:

- lack of consultation about the NHI proposal to date;
- the likely pace of change (which is related to references by ANC officials to the desire to implement the NHI within 5 years); and
- the affordability of the proposed NHI and what contributions by formal sector workers will be required to fund it.

5.3 Critical analysis of current NHI debates

5.3.1 Clarifying the objectives of the proposed NHI

The starting point for critically evaluating the current debates about introducing a NHI in South Africa should be to identify the objectives of the proposed substantial health system change. Based on the review of stakeholder views, there appears to be wide agreement that the fundamental objective is to address the public-private mix inequities and to achieve a universal health system (Boxes 1, 2 and 3). Even the DA, which is the only organisation to explicitly oppose a NHI, has stated (see Box 1):

We need to work towards a more equal healthcare system, narrowing the level of service between the rich and the poor ...[with the] aim of finding the most just, efficient and economic system of providing every single South African with decent health care.

Given that the objective of universality is unanimously supported by all stakeholders, it is important to explore this concept in some detail. WHO has defined a universal health system as one that provides all citizens with adequate health care at an affordable cost (Carrin and James, 2004). Another important insight into universality is provided by the resolution adopted by the 2005 World Health Assembly calling for health care financing systems to provide universal coverage and protection against the financial risks associated with using health services (WHO, 2005), and noted that 'prepayment and pooling of resources and risks are basic principles in financial-risk protection'. It also stressed that to achieve universality, the health system must enable use of health services when needed in addition to protecting households against the costs of such use.

These definitions highlight a number of key issues:

- **Pre-payment mechanisms**, i.e. payments made by individuals via taxes or health insurance contributions before they need to use a health service, should be the primary means for funding health care.
- **Out-of-pocket payments**, i.e. payments made by an individual patient directly to a health care provider, should be minimised.
- Individuals and households should contribute to funding health care according to their **ability to pay**, and should benefit from health services according to their **need for health care**.
- Every person in a country should be able to benefit from health care, which highlights the breadth of coverage that countries should strive for.

It is unlikely that these principles would be opposed by any of the stakeholders whose views were explored in the previous section. The issue on which the above definitions do not give resolution relates to the depth of coverage, in that the services to which people should have access would be determined in relation to what is affordable within the context of individual countries' resources. This highlights a key element of the debate in the South African context, namely, what is affordable? And, should the emphasis be on assuring that everyone gets access to as comprehensive and as high a quality of service as possible or, as in the words of some stakeholders (particularly the DA and Discovery Health), should the emphasis be on providing 'decent' care for all? The latter formulation suggests seeking to provide a 'decent' minimum while allowing those with the means to access a far more extensive package of care. This in turn could translate into a health system with potentially large differentials in the quantity and quality of health care to which different groups have access on the basis of their ability-to-pay.

It is on this issue that it is important to recognise that stakeholders, even those who have stated their opposition to a NHI, agree that the existing differentials in the South African health system are no longer tenable and should be diminished. While there is a commitment to dramatically reduce these differentials, it is recognised that they will not disappear completely, certainly not in the short-term.

5.3.2 Insights into universal cover from international experience

The focus on achieving universal coverage is very much in line with recent international developments, as highlighted by the emphasis on universalism by the WHO³ and in World Health Assemblies. Until recently, the conventional wisdom was that the way to promote greater pre-payment funding of health care was through a gradual process of insuring those in formal sector employment, and expanding coverage as the economy and formal employment grows. The informal sector could potentially be drawn in (as in Korea) if it was a small proportion of the overall population (Carrin and James, 2004).

However, this conventional wisdom is changing, based on detailed study of international experience. A key insight from international experience is that when a gradualist approach is adopted in low- and middle-income countries, where employment levels are rising very slowly, the process of slow extension of insurance coverage can itself become an obstacle to achieving universal coverage. Several Latin American countries, for example, which began a mandatory insurance scheme many decades ago, covering only formal sector workers and their dependents, have found that this system has become entrenched and is proving an obstacle to extending coverage to the rest of the population (Ensor, 2001). Those in the privileged position of having such insurance cover resist efforts to expand coverage, particularly because it will require greater income cross-subsidies on their part. This occurs because the newly insured are likely to be in lower wage categories and if they receive the same package of services as the currently insured, higher income groups will have to contribute more.

Another key insight from international experience is that health systems with an integrated health care pre-payment funding pool are the most successful. As expressed by Davies and Carrin (2001), two WHO officials:

There is growing consensus that, other things being equal, systems in which the degree of risk-pooling is greater achieve more. Risk-pooling is beneficial

³ The 2010 World Health Report is being devoted to the issue of universal coverage.

because health care costs are generally unpredictable and sometimes high. People cannot reliably forecast when they will fall ill and need to make use of health services. When it happens, the costs of those services can be significant. Risk-pooling increases the likelihood that those who need health care will be able to obtain it in an affordable and timely manner. It allows resources to be transferred from the healthy to the sick. From the viewpoint of individuals and households, contributions during times of good health can be used to meet health care costs in the event of illness. In many cases, pooling also contributes towards redistributive goals by making those with higher incomes contribute more in order to subsidize the poor.

The key issues highlighted in this quote (apart from the importance of pre-payment funding mechanisms) are that an integrated pool allows for the greatest possible income- and risk- cross-subsidies (i.e. subsidies from the wealthy to the poor and from the healthy to the ill). A single funding pool achieves the greatest possible integration and cross-subsidies. Davies and Carrin (2001) also highlight in their paper that integration promotes efficiency, such as in terms of administration costs. In contrast, the consequence of allowing fragmentation of funding pools is most clearly demonstrated by the experience of Chile (see *Box 4*).

Box 4: Increased fragmentation of fund pools in Chile

For decades, formal sector workers in Chile had to contribute to mandatory health insurance, which consisted of two public schemes, one for blue-collar workers, the other for white-collar workers. In 1981, a reform was introduced allowing employees to opt out of the public schemes and sign up with a private health insurance scheme. Contributions to the public scheme are community-rated, whereas contributions to the private schemes are to some degree risk-rated. All workers are required to contribute 7% of their income to the health insurance scheme of their choice. However, if a worker belongs to a private scheme and is regarded as a high-risk enrollee, he or she either has to contribute more than 7% or accept a reduced benefit package, whereas if the worker is in a public scheme, he or she receives the same benefit package for the 7% contribution, whatever the level of risk. The result is that the healthier and wealthier are heavily concentrated in the private schemes and the less healthy and less wealthy, in the public schemes.

Sources: Barrientos and Lloyd-Sherlock, 2000; Sapelli, 2004

The growing preference for a single pool of funds has also been informed by the experience of countries with a number of separate pools, or competing insurance schemes, even where there is an attempt to provide some integration through risk-equalisation mechanisms. Not only are administrative costs relatively high, large marketing costs are incurred as schemes compete for members. Also it is difficult to design effective risk-equalisation mechanisms and they are information intensive and costly to maintain. Indeed it is for these and other reasons that in 2000, Korea integrated 139 separate private insurance associations, 227 insurance associations for the self-employed, and numerous other insurance associations into a single National Health Insurance Corporation (NHIC, 2001).

Thus, the international 'conventional wisdom' has shown a dramatic shift in favour of pursuing pre-payment health care funding mechanisms in a way that promotes integrated, rather than fragmented, fund pooling. But how is this relevant this to (LMICs), where the 'conventional wisdom' was that they were doomed to high levels of OOP spending? Certainly LMICs have historically had a very high proportion of their health care funds attributable to OOP spending. However, recent cross-country comparative analyses make clear that there is a very strong relationship between OOP payments and public funding of health care.

As illustrated in *Figure 18*, OOP spending as a proportion of total health care expenditure declines as public spending as a proportion of gross domestic produce (GDP) increases. Based on the fitted trend line, *Figure 18* shows that, in general, countries which devote 4% of GDP to public health care funding can limit OOP spending to about 30% of total health care expenditure. Where 5% of GDP is devoted to public spending on health care, this can limit OOP spending to 20% or less of total expenditure. Therefore, even LMICs can take active steps to limit OOP spending and provide financial protection to citizens, by increasing the level of public spending on health care (including donor funding, general tax funding and mandatory health insurance contributions).

These observations in fact point to a key change in the 'conventional wisdom' in relation to how LMICs should set about achieving a universal health system. The focus now is firmly on how to increase public funding for health services in LMICs. Where public funds come from more than one source (e.g. general tax revenue allocations and mandatory health insurance contributions and/or donor funds), the focus is also on integrating these funds.

For example, the sector-wide approach (SWAp) and general budget support are now the preferred donor funding mechanisms (McIntyre, 2007). Also, a growing number of LMICs, as diverse as Ghana and Kyrgyzstan and Moldova, are pooling general tax revenue allocations with mandatory health insurance contributions within a National Health Insurance Fund.

This is the international context within which the proposed NHI for South Africa should be assessed.

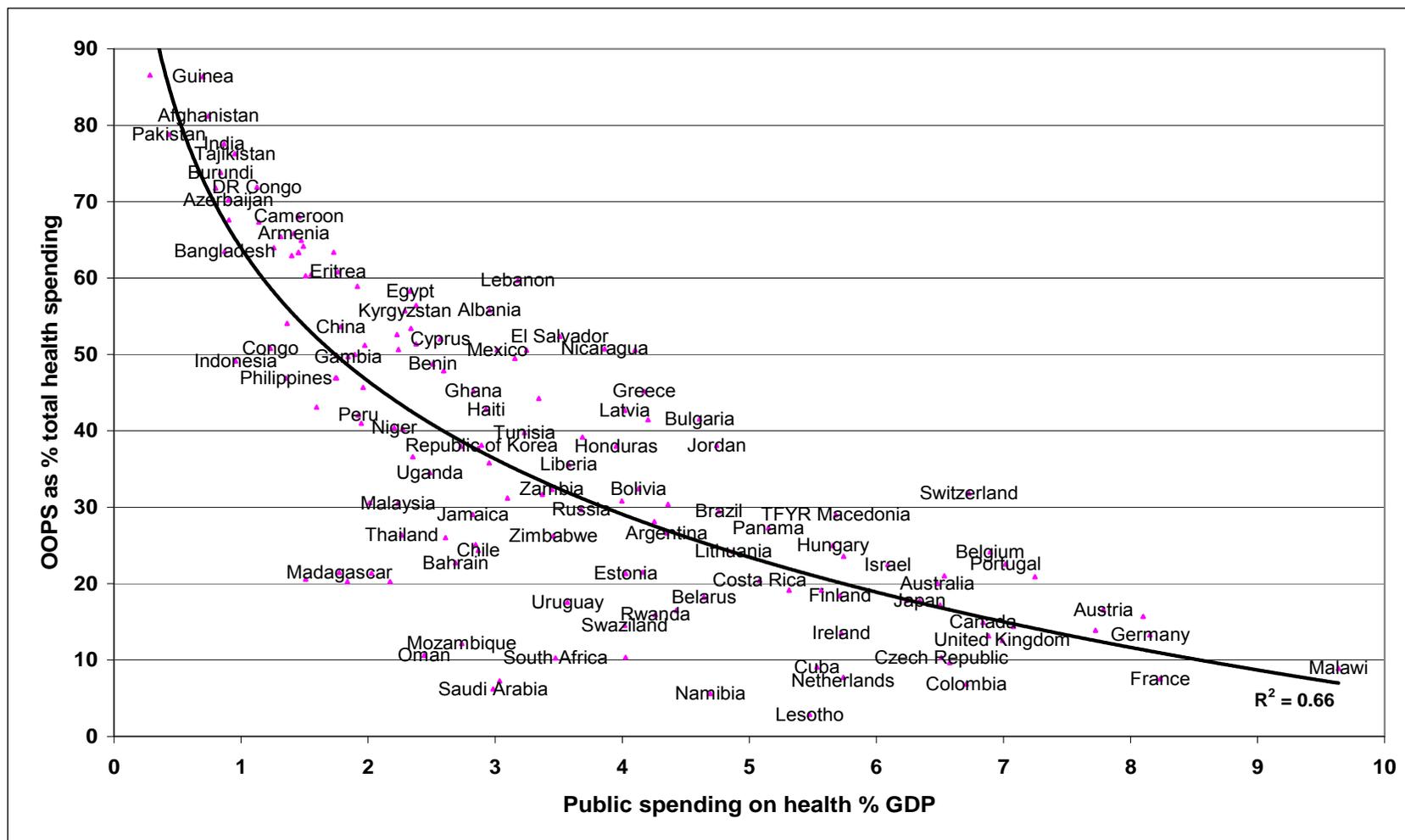
5.3.3 Suitability of the proposed NHI to meet these objectives

Having explored the objectives of the proposed NHI and key lessons from international experience in relation to the objective of universal health systems, the next issue is to consider whether the ANC's proposed NHI is an appropriate vehicle for meeting these objectives, or expressed differently, how might a NHI achieve these objectives. This can only be done to a limited extent, given the absence of publicly available detailed proposals.

On the positive side of the proposals, there is a commitment to reducing out-of-pocket payments, as South Africans would not be expected to pay any fees directly for services covered by the NHI. This is very much in line with international efforts to promote pre-payment mechanisms rather than out-of-pocket payments for health care funding and is important in achieving universal financial protection. There may be some who believe that there should be 'co-payments' to avoid the potential for 'excessive use' of services and to promote cost containment. However, there is a wealth of international experience which demonstrates that co-payments often do not achieve the cost containment objectives and simply serve as a barrier to health service access for lower-income groups (e.g. the Korean experience).

As Kutzin (1995) noted: 'Although incentives to consumers based on cost-sharing requirements appear to have some effect in reducing demand, incentives to providers are much more powerful tools for containing costs.' A review of cost-containment strategies, echoed this view, concluding that 'patient charges do not appear to be a successful cost-containment tool' (Carrin and Hanvoravongchai, 2002).

Figure 18: Relationship between OOP payments and public spending on health care



Source: McIntyre and Kutzin, forthcoming

The other critical dimension of the proposals, from the perspective of achieving the objective of a universal system, is the commitment to having an integrated pool of public funds and to using this integrated pool of funds to purchase a uniform package of health services for all. As indicated in the previous section, this will maximise the potential for income and risk cross-subsidies in the health system, can promote administrative efficiency and is a powerful mechanism in addressing health care expenditure increases due to the substantial purchasing power of a very large fund.

However, in the South African context, it is not simply an issue of having an integrated pool of public funds, but also at issue is the size of the pool of public funds, which will be used to purchase services for everyone's benefit, relative to the size of the medical schemes' funding pool, which serves a minority. As argued in section 4.3, the fact that the medical schemes' pool is larger than the current tax pool (albeit only marginally larger at this stage), relative to the population covered by each pool is creating problems in the overall health system.

If the integrated pool of public funds is to provide universal coverage (even if some people choose not to use the services offered and instead take out duplicative medical scheme cover), and most importantly if this public funding pool is to draw on all the health human resources in the country (whether currently working in the public or private health sectors) the relative size of the two pools must change dramatically. The public funding pool should be considerably larger than the medical scheme pool. While this may be partly achieved by improved efficiency in purchasing and provision in what currently comprises the private health sector, as there will be substantial pressure on medical schemes to improve value for money to secure ongoing support of at least some of their current membership, it is also possible that the growing pool of public funds may begin to 'crowd out' funding flows to medical schemes.

In this regard, the proposal to introduce a mandatory health insurance contribution for formal sector workers is likely to assist this 'crowding out' process. While it may be possible to entirely fund the reformed health system through general tax revenue, introducing an explicit NHI contribution will force current medical scheme members to seriously consider if ongoing scheme membership is necessary and if they are getting value for money from schemes. In this sense, a NHI contribution can contribute to changing the relative size of the public funding and medical scheme pools in a way that simply funding a universal package of health services from general tax revenue would not. This does not mean that the NHI contribution would replace allocations to the health sector from general tax revenue; a universal publicly funded health system will likely require bigger allocations from general tax revenue.

Therefore, the broad proposals on the funding mechanism seem to provide a good basis for addressing some of the current challenges in the South African health care system and for achieving the goal of universal coverage. However, the success of this funding strategy is heavily dependent on the services that will be covered by the proposed NHI and the perceived access to and quality of these services. In this regard, the commitment to dramatically improving public sector services on which the majority currently rely and to apply a common set of quality criteria to public and private providers alike, also bodes well for moving towards a universal health system.

However, the size of the task of turning around public health care services given the considerable damage done through systematic underfunding of these services since the mid-1990s (see *Figure 14*) should not be underestimated. Alongside these service improvements, public perceptions of poor quality of care in the public sector must be actively addressed. Only if citizens regard the quality and range of services covered under the proposed NHI as meeting their needs and preferences will they

support this reform initiative. If these issues are not addressed, imposing a NHI on South Africans could translate into widespread public opposition.

A related issue is that the proposal states that the NHI will purchase services from both public and private providers, but is unclear on how this will work in reality. The practical details of the ability of South Africans to choose their provider are also unclear. There is a real risk that class divisions in the use of public and private providers will remain, not least of all because private providers are primarily located in the wealthiest areas and will be the nearest and preferred providers for richer groups. In addition, the apparently common perception that private sector services are of superior quality to public sector services, despite various studies demonstrating the generally superior clinical quality of care in the public health sector (Mills et al, 2004; Connolly et al, 1999; Schneider et al, 2001), will undoubtedly be used by private for-profit providers to argue for a bigger role in health care delivery under an NHI. The extent of the role of private for-profit providers in a future NHI is likely to be of critical importance in terms of the affordability and sustainability of the universal system, given the recent history of private for-profit providers (particularly hospitals and specialists) having greater power than purchasers in influencing prices. This once again highlights the importance of addressing the current under-resourcing of public sector facilities and addressing public perceptions actively to provide a countervailing effect on the current power of private for-profit providers.

Many of the concerns raised by key stakeholders relate to the affordability and sustainability of the proposed NHI. Careful estimation of the resource requirements for the proposed NHI is required and it is likely that some trade-offs in design will be needed. Two issues of considerable importance in relation to ensuring the affordability and sustainability of a reformed health system are:

- International evidence shows that there must be effective primary care gate-keeping. Therefore, adequate attention must be paid to transforming primary care services and empowering providers at this level to be effective gatekeepers who are trusted and respected by South Africans.
- Provider reimbursement mechanisms, particularly in terms of the payment of private providers, must be reformed. The NHI proposals indicate that there will be a move away from fee-for-service payments to capitated- and related-reimbursement models. However, limited information is available on precisely how provider payment systems will work.

Another factor that will influence the affordability and sustainability of a reformed health system relates to efficient management and administration. Again, there are very few details on this issue available, apart from indicating that there will be a separate NHI Fund responsible for purchasing health services and some other functions. Some stakeholders are concerned that this could result in expensive administrative structures and duplication of functions that are currently the responsibility of the national and provincial Departments of Health. It will be essential to clearly map out the different functions of the health departments and the NHI Fund to avoid confusion about responsibilities, lines of accountability and duplicative bureaucracies.

In essence, there are still many areas where clarity is lacking. Nevertheless, the key elements of the funding mechanism appear to be in line with the objectives of universal financial risk protection and access to needed care. What is now required is more detailed technical work on key elements of the purchasing and provision design and the setting of realistic time-frames for implementing the massive reforms required in the health system. Finally, there has to be wide-scale support for these reforms if they are to be successfully implemented, which can only be achieved

through extensive engagement with key stakeholders, not least of all the intended beneficiaries of this reform, namely citizens, as well as front-line health workers and managers who will be expected to work within the reformed health system.

6. Implications for east and southern Africa

The implementation of the proposed NHI in South Africa is likely to have profound implications for other African countries. In the recent past, many South African firms, including those in the private health care sector, have expanded their business to other African countries. A number of medical schemes have set up private health insurance organisations in other countries, pharmaceutical companies such as Aspen have operations in a number of East African countries (Kenya, Tanzania and Uganda), while private hospital groups have established facilities in southern African countries (e.g. Medi-Clinic in Namibia and Life in Botswana). Most recently, Netcare has entered into a public-private partnership with the government of Lesotho to run a 390 bed hospital.

The private health sector perceive the proposed NHI as reducing investment opportunities in South Africa and anecdotal evidence indicates that many private health sector organisations see expansion into the rest of Africa as a lucrative option, as confirmed by an article on the largest private hospital company, published in the *Financial Mail* (Mzolo, 2009):

Netcare is not sitting back and waiting or hoping for government to improve the investment landscape in SA. Private hospital companies battling to expand locally are now looking elsewhere for growth. ... In countries such as Zambia and Namibia, Netcare is conducting feasibility studies with a view to setting up PPP or co-location projects. ... It helps that there's a list of agencies including the Development Bank of Southern Africa and the World Bank's International Finance Corp keen on investing in health care in Africa today. Netcare is casting its net wider and looking at the likes of the Central African Republic, Ghana and the big fish, Nigeria, where new, fully fledged private hospitals are on the cards. ... Zimbabwe is also on the radar. Netcare CEO Richard Friedland has just returned from Harare — where he met President Robert Mugabe, Finance Minister Tendai Biti and other big shots.

Private health care firms in South Africa have an interest in expanding into other African countries and they will also have access to substantial investment resources, such as the World Bank's International Finance Corporation (IFC), which is actively seeking to invest in the private health sector in African countries. McKinsey (an international consultancy group) in collaboration with the IFC and the Bill and Melinda Gates Foundation recently undertook an investigation of the health care investment opportunities in Africa (Ghatak et al, 2008). They argue that:

In the coming decade, sub-Saharan Africa's health care market will grow briskly, and the private sector's share of it will increase ... Our research suggests that sub-Saharan Africa's health care expenditures [excluding South Africa] will more than double by 2016, to \$35 billion a year. The private sector will likely garner 60 percent of this amount. To meet the increased demand, about \$25 billion to \$30 billion in total incremental investment is required by 2016 to finance physical assets such as hospitals, clinics, and drug-distribution centers. Governments will certainly receive some of this investment. However, in countries receptive to private-sector activity, we expect that between 45 and 70 percent of the funds will be invested in the private sector.

They further estimate that at least 60% of the investment opportunities will be in the for-profit sector, and conclude that:

[African] *Governments should modify local regulations that impede the development of the private health sector (say, trade barriers that limit access to health supplies or laws that restrict the private sector's role in medical training or its participation in risk-pooling plans) and also strengthen regulatory bodies that can work with reputable businesses to better develop and enforce quality standards. Private donors and governments should **consider earmarking aid** to directly support private-sector entities, and also expand risk-pooling arrangements.* [emphasis added]

Substantial international resources are going to be invested in the private health sector in Africa and South African companies are amongst the best placed to draw on these investment funds. The last sentence of the McKinsey quote highlights a recognition on the part of the global partners driving these investment initiatives that private health insurance ('risk-pooling arrangements') is essential to fund the services of for-profit providers. This suggests that the vision is to replicate the 'model' of the South African private health sector throughout Africa. The above review of the enormous challenges facing the private health sector in South Africa, and the policy decision to change direction towards an NHI in order to secure universal access to health care, raises serious questions about the McKinsey, Gates and IFC's vision.

7. Conclusion

Serious challenges face the private health care sector in South Africa, not least of all very rapid increases in expenditure and, hence, contribution rates in medical schemes. A range of factors underlying these trends, but these have not been addressed effectively either through government regulation or through action by the private health sector itself. These challenges impact on the overall health system, both in terms of its affordability and sustainability and in terms of the ability to achieve the income- and risk-cross-subsidies needed to achieve a universal system.

The proposed NHI aims to achieve universal financial risk protection and access to health care. Implicit in the proposals are strategies to address the current challenges in both the public and private health sectors. While the proposed funding and pooling mechanism for the NHI is in line with international best practice for universal health systems, many details of the proposed NHI, particularly in terms of the purchasing and provision of health services, are still unclear. Stakeholders share widespread agreement that substantial reform of the health system is needed and all stakeholders have stated their support for a universal system and for reducing the public-private health sector differentials in resources relative to the population served. However, it is critical that careful planning is undertaken, that there is extensive engagement with all stakeholders (particularly the oft-forgotten citizens and front-line health workers and managers) and that implementation occurs over a reasonable timeframe if the proposed reforms are to achieve the goal of a universal health system.

If successfully implemented, the substantial reforms envisaged will promote health system equity, affordability and sustainability in South Africa. However, there are growing concerns that the introduction of these reforms will contribute to increased activities by South African private for-profit health care companies in other African countries. The experience of the private health sector in South Africa should be taken into account by policy-makers in other African countries when considering what role they envisage for the private health sector in their country context.

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Glossary of terms

Adverse selection: the likelihood that a person with a high risk of illness and a greater need for frequent health care will be more likely to enrol in a health insurance scheme than a person with a low risk of illness and less need for frequent health care use

Breadth of coverage: the proportion of the total population covered by health insurance

Capitation payment: usually, a negotiated payment paid for an agreed period of time by an insurance scheme to a health care provider per person covered by the scheme and receiving health care from the provider

Catastrophic expenditure: expenditure at such a high level as to force households to reduce spending on other basic goods (e.g. food or water), to sell assets or to incur high levels of debt, and ultimately to risk (further) impoverishment

Community-rated contribution: a contribution to health insurance calculated on the basis of the insurance claims profile of the entire community or of the insurance scheme, or on the basis of the average expected cost of health service use of the entire insured group rather than of an individual

Co-payment: out-of-pocket, partial payment by a health insurance member for health services used in addition to the amount paid by the insurance: the aim is to place some cost burden on members and thereby discourage them from excessive use of health services

Cream-skimming or cherry-picking: the practice whereby an insurance scheme enrolls a disproportionate percentage of individuals (e.g. young people) who present a lower than average risk of ill-health

Depth of coverage: the composition of the health insurance benefit package — the more comprehensive the package, the greater the depth of coverage

Formal sector: the official sector of the economy, regulated by society's institutions, recognised by the government and recorded in official statistics

Mandatory health insurance: a health insurance scheme to which certain population groups or the entire population must belong by law; such schemes are founded on the principle of social solidarity, whereby individuals contribute to the insurance according to their ability to pay (or their income) and benefit from coverage according to their need for health care

Moral hazard: the tendency for entitlement to benefits under health insurance to act as an incentive for people to consume more and 'better' health care than they would if they were not covered by insurance

National health insurance: a mandatory health insurance scheme that covers all or most of the population, whether or not individuals have contributed to the scheme

Opt out: Some countries that have a mandatory health insurance allow people to 'opt out', i.e. they are allowed to take out private health insurance and not contribute to the mandatory insurance pool

Out-of-pocket payment: payment made by an individual patient directly to a health care provider, as distinct from payments made by a health insurance scheme or taken from government revenue

Progressive contribution mechanism: a financing mechanism whereby high-income groups contribute a higher percentage of their income than do low-income groups

Proportional contribution mechanism: a financing mechanism, whereby everyone contributes the same percentage of income to a health insurance scheme, irrespective of income level

Regressive contribution mechanism: a financing mechanism whereby low-income groups contribute a higher percentage of their income than high-income groups

Risk-equalisation: a mechanism whereby revenue accruing from contributions to several health insurance schemes or health funds acting as financing intermediaries (i.e. organisations that receive contributions and pay health care providers) for a social health insurance system is pooled and the individual schemes allocated an amount which reflects the expected costs of each scheme according to the overall ill-health risk profile of its membership

Risk-rated contribution: the contribution an individual or group pays to an insurance scheme adjusted to the level of the individual's or group's risk of illness, expected future cost of health care use or past claims experience

Social health insurance: a mandatory health insurance to which only certain groups (frequently formal sector employees) are legally required to subscribe or which provides benefits only to those who make insurance contributions

Supplier-induced demand: where more services are provided than are 'clinically necessary', such as more than necessary diagnostic tests or more frequent than necessary repeat 'check-up' visits where these services are initiated by the health care provider; frequently linked to fee-for-service payment mechanism, which provides an incentive for providers to deliver as many services as possible to generate more income.

Voluntary health insurance: a health insurance, to which an individual or group can subscribe without a legal requirement to do so

Acronyms

ANC	African National Congress
BEE	Black Economic Empowerment
BHF	Board of Healthcare Funders
CEO	Chief Executive Officer
CMS	Council for Medical Schemes
CPI	Consumer Price Index
CT	Computed Tomography
DA	Democratic Alliance
DG	Director General
DoH	Department of Health
GDP	Gross Domestic Product
GEMS	Government Employees Medical Scheme
GP	General Practitioner
HPCSA	Health Professions Council of South Africa
HASA	Hospital Association of South Africa
IES	Income and Expenditure Survey
JSE	Johannesburg Stock Exchange
LMIC	Low- and Middle Income Countries
MEC	Member of Executive Council
MRI	Magnetic Resonance Imaging
NHI	National Health Insurance
NHRPL	National Health Reference Price List
OECD	Organisation of Economic Cooperation and Development
OOP	out-of-pocket
OTC	over-the-counter
PPP	Public-Private Partnership
RAMS	Representative Association of Medical Schemes
RWOPS	remunerated work outside public service
SACBIA	South African Consortium for Benefit Incidence Analysis
SAMA	South African Medical Association
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SARS	South African Revenue Service
SHI	Social Health Insurance

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET:

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