PERSPECTIVES ON A NATIONAL HEALTH INSURANCE

15

NATIONAL HEALTH INSURANCE: PROVIDING A VOCABULARY FOR PUBLIC ENGAGEMENT

Author:

Di McIntyre[i]

A key area of contention has been whether a universal system is affordable or not. It is not the universality of a universal health system that makes it unaffordable, it is inappropriate design of a health system that can make it unaffordable...

There has been considerable confusion and media debate about the proposal to introduce a national health insurance (NHI) in South Africa. The purpose of this chapter is to demystify the proposed health system reform. It explains the objective of the proposed reform, evaluates how South Africa currently fares relative to this objective and explores the implications of lessons from international experience for the South African health system. It also considers what is required to ensure that a reformed health system is affordable and sustainable.

This chapter argues that the term 'NHI' has itself contributed to the confusion about the intended reform and that the focus should instead be placed on the core objective of the reform, which is to achieve a universal health system. A universal system is one that ensures that everyone is able to use health services when needed and that provides financial protection against the costs of health care for everyone. The reality is that many South Africans cannot access health care when needed.

Another misconception is that the proposed reform is simply about how to fund health services. Instead, it is very much about ensuring that South Africans have real access to appropriate, efficient, quality health services.

A key area of contention has been whether a universal system is affordable or not. Not only is it premature to declare the NHI unaffordable when there are no details of the proposed reforms in the public domain, but it is also important to recognise that it is not the universality of a health system that makes it unaffordable. It is, instead, inappropriate design of a health system that can make it unaffordable.

There is neither doubt that health system change is needed in South Africa, nor dispute that it is possible to achieve an affordable universal system. What is required is constructive and evidence-informed debate from all stakeholders on how best to achieve improved health for all South Africans through health system reform.

i Health Economics Unit, University of Cape Town

Introduction

South Africa has a long history of policy debates about fundamental health system reform to better meet the health needs of South Africans. The first major development was the recommendation by the 1928 Commission on Old Age Pensions and National Insurance (chaired by BJ Pienaar) that a health insurance scheme should be established to cover medical, maternity and funeral benefits for all low-income, formal sector employees in urban areas.[1] This was followed in 1935 by the Committee of Enquiry into National Health Insurance (chaired by James Collie) that made similar proposals to those of 1928.[2] The proposals from these committees were not taken forward.

The 1942-1944 National Health Services Commission (chaired by Henry Gluckman), in contrast, recommended the introduction of a national health tax to ensure that health services could be provided free at the point of service for all South Africans. The aim was to bring health services "within reach of all sections of the population, according to their need, and without regard to race, colour, means or station in life".[3] Health centres, providing comprehensive primary care services, were proposed as a core component of the health system. Although the Gluckman Commission proposals were accepted by the Smuts government, it was decided to implement them as "a series of measures rather than in a single step".[4] The introduction of community-based health centres was taken forward, with 44 centres being established within two years. However, other aspects of the proposals were never implemented. Any gains from the Gluckman Commission process were reversed after the Nationalist Party government was elected in 1948.[5]

There was relative silence on substantive health system reform during the apartheid years, but academics and progressive health organisations began calling for a tax-funded national health system in the 1980s.[6-9] By the early 1990s, the spotlight had again turned to the possibility of introducing some form of mandatory health insurance[10,11] and, after the 1994 election, there were several policy initiatives that considered either a social or national health insurance.[a,12-15] A detailed review of these different policy proposals, none of which were taken forward, was provided in a previous South African Health Review.[16]

The African National Congress (ANC) resolved at their 2007 policy conference in Polokwane to implement a national health insurance (NHI) in South Africa.[17] This was followed by an internal process within the ANC to develop a broad NHI policy vision. In late 2009 a formal government process was initiated with the establishment of the Ministerial Advisory Committee (MAC) on NHI tasked with developing detailed health system reform design proposals. The Minister of Health is yet to release a formal NHI policy document, but it is expected that some form of policy document will be released for public comment and engagement in the near future.

Despite the fact that no formal policy proposal has been placed on the table, there has been considerable speculation by key health sector stakeholders and the media on the form that this reform may take, with some declaring that an NHI is unaffordable. Release of a formal policy document will allow commentators to move from speculation to constructive debate.

The use of the term NHI has itself created much of the confusion and misinterpretation of the intentions of government. The term 'insurance' has tended to lead South Africans to envisage a type of 'insurance scheme' – probably due to our exposure to medical schemes. As pointed out by Kutzin, the term 'insurance' in essence refers to the policy objective of providing financial protection against the very uncertain and potentially high costs of health care, rather than a specific policy instrument, i.e. an insurance scheme. 'Insurance' – in the sense of providing financial protection against health care costs for the population – can be achieved through a range of policy instruments, including tax revenue and insurance schemes.[18]

In this chapter the term 'universal coverage' (UC), which is both more descriptive of the objective of the reform and less open to misinterpretation, will be used. The use of the term UC is consistent with the statement by the Minister of Health in the debate on the health budget in the National Assembly on 30 June 2009 that

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

The late Deputy Minister of Health stated on the same occasion that the envisaged health system reform,

> 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.

a The terms social health insurance (SHI) and national health insurance (NHI) are often used inter-changeably in the international literature. They both refer to a form of mandatory health insurance, i.e. where legislation is enacted that requires some or all people to contribute to a health insurance scheme. In South Africa, SHI has generally been used to refer to a mandatory health insurance scheme which would only cover those who contribute to it (e.g. the formally employed and possibly their dependants), while NHI has been used to refer to a mandatory insurance scheme which would cover all citizens, irrespective of whether or not they contributed to it.

The preference for the term UC, and indeed the focus on UC as the policy objective of reform of the South African health system, is also in line with international trends. Of particular note is the World Health Assembly resolution in 2005 calling for member states to pursue universal coverage and sustainable health financing.[19] It is also of note that the 2010 World Health Report is devoted to the issue of universal coverage.

Another misconception that the use of the term NHI has created, is that the proposals for health system reform in South Africa only relate to money or funding of health care. Thus, in an attempt to avoid creating further confusion about the nature of the proposed health system reform in South Africa, this chapter will focus on the key 'functions' of a health care financing system, all of which will be addressed in the reform. The three core functions are:

- Revenue collection, which relates to how to raise the necessary funds for the health system (who contributes and how the contributions are structured);
- Pooling, which includes issues such as the coverage of the population, group composition of a specific pool of funds, and the number of different pools; and
- Purchasing, looks at what type of services are covered and the mechanism(s) by which providers are paid.[20,21]

The main objective of this chapter is to try to demystify the proposed health system reform. The following section explains the concept of UC, the core objective of the proposed reform. Thereafter, the current South African health system is briefly considered in relation to the objective of UC. This is relevant as substantial health system reform is only warranted if the existing health system is failing to achieve core policy objectives. The next section briefly reviews key lessons from international experience in terms of the above-mentioned core functions of a health care financing system. Thereafter, a review is provided of the implications for the South African health system and how UC may impact on progress towards the Millennium Development Goals (MDGs).

The main constraint in preparing this chapter is the continued absence of a policy document on the reform proposals in the public domain. This chapter, therefore, reflects the author's understanding of what is being proposed, based on information that is in the public domain. As the full technical details of the reform are still being considered and as wide engagement on the reform proposals is expected, the precise design of the UC reform cannot be predicted with certainty by anyone. For this reason, it is only feasible to outline the broad parameters of the intended reform.

What is universal coverage?

The World Health Organization (WHO) has defined a universal health system as one that provides all citizens with adequate health care at an affordable cost.[22] There are a number of other formulations of the definition of universal coverage but these definitions all have two elements in common. Firstly, a universal health system should ensure that all are able to use needed health services by eliminating barriers to service access (the issue of 'adequate health care' in the above definition). Secondly, UC should provide financial protection for all against the costs of health care, with it now being widely accepted that "pre-payment[b] and pooling of resources and risks are basic principles in financial-risk protection".[19] It is this issue of financial protection that is the key focus in terms of 'affordable cost' in the above definition although, clearly, affordability of the health system within the context of a country's economic resources is also important.

Underlying this understanding of universal coverage are the equity principles of:

- contributing to funding health services according to ability-to-pay; and
- benefiting from health care according to need.

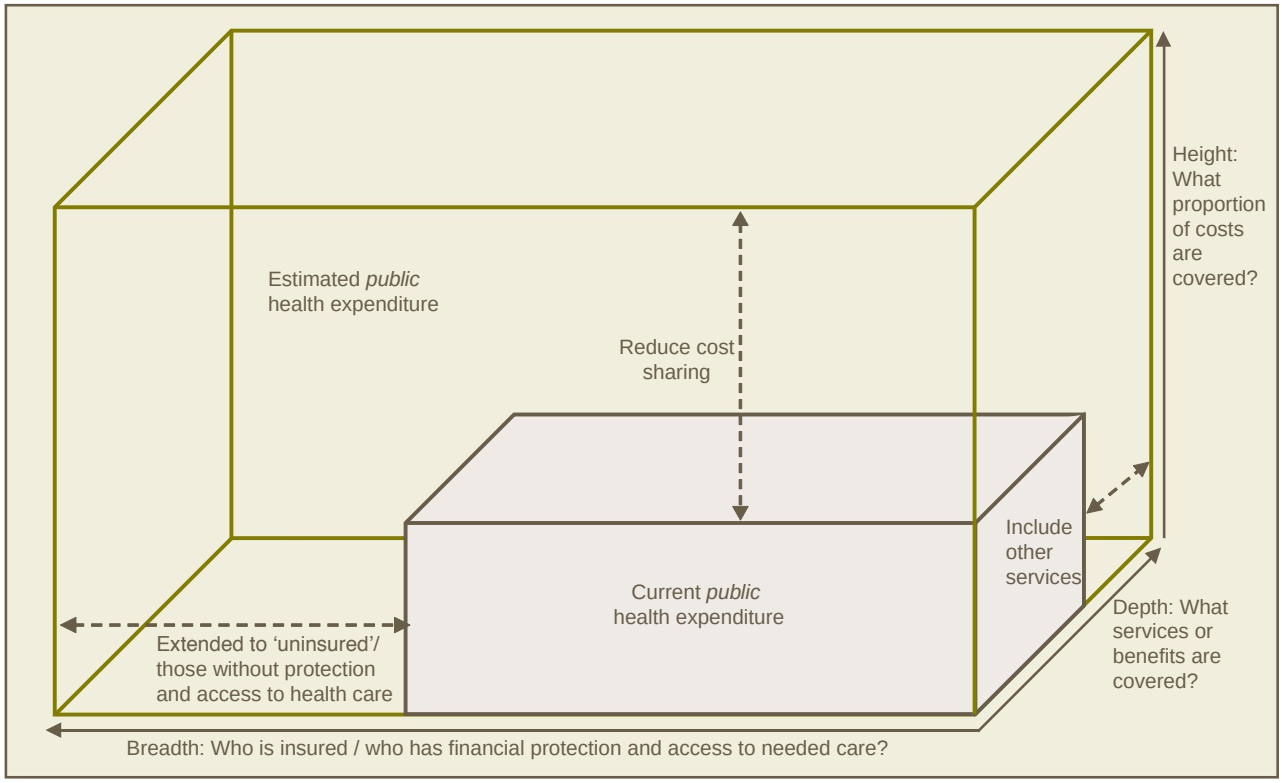
Another useful way of understanding universal coverage is illustrated in Figure 1. Moving towards a universal health system requires expanding coverage in three ways:

- The *breadth* of coverage, which refers to the proportion of the population that has financial protection and access to needed health services;
- The *depth* of coverage, relating to the extent to which the range of services necessary to effectively address people's health needs is covered; and
- The *height* of coverage, which concerns the portion of health care costs that is covered through pooling and pre-payment mechanisms.

Mathauer emphasizes that assessing progress towards UC is done by comparing the potential maximum breadth, depth and height of coverage relative to current public health expenditure.[23] The notion of public funding and expenditure relates to resources that benefit all citizens (i.e. it does not necessarily refer only to tax funding), as opposed to private expenditure which only benefits those who contribute to funding such expenditure. This is at the core of the concept of UC; UC relates to all people (rather than a select group) benefiting from extended coverage.

b Payments made by individuals to a 'pool' on a regular basis and not related to their use of a health service, i.e. via taxes and/or health insurance contributions.

Figure 1: Graphical presentation of breadth, depth and height of coverage



Source: Mathauer, 2009.[23]

Mathauer identifies mechanisms by which countries can move towards UC in terms of the three dimensions of coverage outlined in Figure 1. Maximum breadth of coverage will be achieved by extending financial protection and access to needed health care to that portion of the population who are currently not protected financially and who experience barriers to accessing services. Extending the depth of coverage requires expansion of the package of health services to ensure that an accessible and comprehensive range of services is provided in relation to meeting the most pressing health needs of the population. Finally, the height of coverage will be improved by reducing the extent to which the use of the health services is funded through out-of-pocket payments, by increasing pre-payment funding.

How does South Africa fare in terms of universal coverage?

The framework outlined above is used to assess how South Africa fares in terms of universal coverage. As we have a divided health system, the issues of breadth, depth and height of coverage are considered both for those covered by medical schemes and those dependent, partly or fully, on tax-funded services.

In relation to the breadth of coverage or the size of the population that has at least some financial protection against the costs of using health services when needed, about 16% of the population are currently members of a medical scheme. Coverage by health insurance schemes is, therefore, extremely limited in South Africa. Membership of such schemes is largely restricted to the wealthiest groups, with 71% of medical scheme members being in the richest quintile and 18% in the second richest quintile of South African households.[24] Membership of a medical scheme does appear to improve access to needed health care. A recent household survey found that while 10% of those without medical scheme membership did not seek health care in the previous month, despite reporting their health status to be poor or very poor, this was the case for less than 4% of medical scheme members.[24]

General tax funding is the mechanism for providing financial protection and access to care for the vast majority of South Africans. All South Africans are entitled to use tax-funded health services but are expected to contribute something towards the cost of these services. Only public sector primary health care services are provided without a user fee being charged. For hospital services, everyone is expected to pay a user fee, which varies according to a person's income level, unless they can prove that they are indigent. The requirements for proving indigence can be onerous, however, and the existence of user fees at the point of service delivery does create a barrier to using health care when needed.[25,26]

Although in theory South Africans enjoy a fair amount of financial protection via health services that are either fully tax-

funded or heavily subsidised, the reality is that many cannot access services when needed. There are many access barriers, but a recent national household survey has indicated that one of the greatest barriers to access remains distance to facilities. The overall average travelling time to a health facility (averaged across all modes of transport) for the poorest 20% of households is nearly 40 minutes. While 40% of the poorest households walk to the health facility, over 50% use public transport. The necessity to use public transport if one does not live within walking distance of a health facility comes at a very high price; spending on transport for a single visit to a health facility is an average of 11% of monthly household expenditure for the poorest 20% of households.[24]

In terms of the depth of coverage (or the extent to which the range of services covered effectively addresses the needs of the population), medical schemes cover a limited but very specific range of services. In particular, schemes are required to cover a prescribed minimum benefit (PMB) package, consisting of a list of 270 diagnosis and treatment interventions provided primarily on a hospital inpatient basis, and a list of 25 common chronic diseases. Most schemes also cover other services over and above the PMBs, with each scheme having a different benefit package. There are, however, very specific limits on these additional benefits, e.g. a maximum amount that can be spent on ophthalmology services per year or a maximum number of visits to a general practitioner in a year. Some schemes provide a relatively comprehensive service package, but require a high contribution, while others cover little more than the PMBs. There are clearly gaps in the depth of coverage via medical schemes in South Africa.

Tax-funded services incorporate a relatively comprehensive range of services, from primary care services at clinics through to highly specialised services in provincial and central hospitals. However, there are limitations on the range of services provided, largely due to resource constraints, and there is some health service rationing. For example, there are constraints on the number of heart transplants that can be undertaken and the number of patients that can be placed on dialysis at any one time. Public sector health professionals are also required to prescribe from the essential drug list, which includes a limited number of mainly generic medicines to treat the most common illnesses.

The height of coverage in South Africa could be described as relatively good, as the majority of health-care funding occurs through pre-payment mechanisms. Out-of-pocket payments only account for 14% of total health-care funding in South Africa, which is relatively low compared to other low- and middle-income countries.[27] Out-of-pocket payments take the form of user fee payments at the point of service at public sector hospitals, direct payments to private providers by those who are not covered by medical schemes and payments by medical scheme members either as co-payments[c] or the full cost of a service which is not covered at all by the scheme.

Over 60% of out-of-pocket payments are made by medical scheme members.[28] This highlights the extent to which medical scheme members are not fully protected from the costs of health care. Co-payments can be high and the disparity between what health-care providers charge and what medical schemes will pay has been growing in recent years. This has particularly arisen since the Competition Commission ruling that it was anti-competitive to produce a tariff schedule, such as the ones formerly produced by the Board of Healthcare Funders (BHF), that formed the basis for reimbursement rates of medical schemes. Although a National Health Reference Price List (NHRPL) has been established, the National Health Act indicates that individual medical schemes may only use it as a guideline when determining their reimbursement rates. Moreover, the Health Professions Council of South Africa (HPCSA) stated that it regarded it as ethical for private generalist and specialist doctors to charge fees of up to 300% of the NHRPL.[29] Fee levels charged by private providers have increased dramatically since this HPCSA statement, but medical scheme reimbursement rates have often not matched these increases.

Less than 20% of the population that are not covered by medical schemes (thus 16% of the total population) use private sector health services on an out-of-pocket basis. This relates primarily to the use of general practitioners and retail pharmacies. A small component (7%) of out-of-pocket payments is attributable to user fees at public sector hospitals.[28]

In summary, the somewhat limited information available on the breadth, depth and height of coverage in South Africa suggests that the largest deficiency at present relates to the breadth of coverage. Out-of-pocket payments (height of coverage) are low relative to many other low- and middle-income countries, but there is scope for further improvement. Depth of coverage (range of services relative to health needs) can also be expanded over time. While there is very extensive breadth of coverage 'on paper', the reality is that many South Africans cannot access health care when needed. Distance to facilities and lack of financial protection from the transport costs to reach facilities that are not within a reasonable walking distance is a particular problem. There are a wide range of other access constraints such as limited opening hours, insufficient staff in some facilities, lack of availability of medicines, poor staff-patient interactions which can deter use, to name a few barriers.[30] Many South Africans simply do not seek health care when in need, while others who do seek care

c An out-of-pocket partial payment by a health insurance scheme 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.

incur costs that are high relative to their household resources. It is meeting the challenge of making accessible health care and financial protection a reality for all South Africans that should be the focus of health system reform.

International experience regarding universal coverage

This section provides a very brief summary of some of the key findings of extensive reviews of international experience, presented in terms of the key functions of health care financing systems – namely revenue collection, pooling and purchasing.[31-33]

Revenue collection

All health care funding ultimately comes from households and firms, either in the form of direct payments (often called out-of-pocket payments) or through pre-payment mechanisms. There are two broad categories of pre-payment mechanisms: compulsory and voluntary. Compulsory pre-payment includes various forms of taxation and mandated contributions for health care (such as payroll taxes or mandatory contributions[d] that are specifically earmarked for health service funding). Voluntary pre-payment mechanisms include different forms of private health insurance (PHI).

In considering what combination of funding mechanisms is most appropriate, the emphasis is usually placed on assessing the relative progressivity of different mechanisms. In progressive financing mechanisms, the rich contribute a higher percentage of their household income to health care funding than the poor, whereas in regressive mechanisms the poor contribute a higher percentage of their household resources than the rich.

The earlier definition of universal coverage highlighted that pre-payment financing mechanisms are regarded as most appropriate in pursuing the objective of UC. Part of the reason for this is that direct (or out-of-pocket) payments are the most regressive way of funding health care. The only instance when they are not regressive is where the poorest households do not make such payments, usually because they do not seek care because they cannot afford it.[34]

Most of the research on the relative progressivity of different financing mechanisms has been undertaken in the Organisation for Economic Co-operation and Development (OECD) countries. The OECD countries with the most regressive health care financing systems were Switzerland (before its recent reforms) and the United States of America (USA). In terms of the most recently available information, the majority of financing in both of these countries was attributable to private funding mechanisms: private insurance accounted for 41% in Switzerland and 29% in the USA while direct payments accounted for 24% and 22% respectively.[35] PHI contributions were regressive in both USA and Switzerland. They were also regressive in France. Although France has a national health insurance scheme, quite high co-payments are imposed, so a large portion of the population takes out PHI to cover these co-payments. However, where PHI is taken out in addition to contributing to and having an entitlement to benefit from publicly funded services (what is called supplementary cover), as in the United Kingdom (UK), it is only accessible to the richest households and so is progressive.[35]

The international evidence indicates that regressivity in overall health care financing can be minimised by clearly defining and limiting the role of PHI in the health system. In particular, PHI should not be a major funding mechanism. However, PHI that covers co-payments or supplements entitlements to publicly funded services, has less regressive effects.

The OECD countries with the most progressive health financing systems, UK and Italy, are those which are very largely publicly funded. About 84% of health care financing in the UK is through public mechanisms, 64% from general tax revenues and a further 20% from mandatory health contributions. In Italy, public financing mechanisms account for 77% of all funds, which is evenly split between general tax revenue (38%) and mandatory health contributions (39%).[35]

There is indisputable evidence that in order to achieve progressive, universal health systems, public funding should account for the major share of health-care financing. Funding from general tax revenue has the potential to be the most progressive health-care financing mechanism, though this depends on the underlying mix of taxes (personal income tax, value added tax and excise duties) as well as how progressively personal income and corporate tax rates are structured. Mandatory health insurance schemes can also be progressive, with the following features promoting progressivity in such schemes:

- the rich should not be permitted to opt out of the scheme (i.e. allowed not to contribute to the scheme);
- the contributions of vulnerable groups (e.g. the unemployed, pensioners, the poor) should be fully or partially subsidised from general tax funds; and
- a cap should not be placed on contributions, i.e. a maximum contribution amount should not be specified, as this results in high income earners paying a lower percentage of their earnings than lower income earners.[31]

d A deduction taken from the 'payroll' by the employer before employees receive their wage or salary and paid to government or another organisation responsible for collecting funds for health care.

Pooling

Health care costs are unpredictable; it is difficult for individuals to know when they will fall ill, what health care they will require and what this health care will cost. Sometimes the cost of care can be very high, particularly for hospitalisation or long-term serious illness such as cancer or AIDS-related diseases, and most people are unable to cover these often unexpected costs by drawing on resources that they have available. While it is difficult to predict health care needs and costs for an individual, it is more feasible to predict these for a group of people drawing on epidemiological and actuarial data. Actuarially, the larger the pool, the greater the ability to predict and spread risks related to ill-health and the more sustainable the funding is. This is the core of the concept of risk-pooling; individuals contribute on a regular basis to a pooled fund (e.g. by paying taxes or contributing to health insurance) so that when they fall ill, the pool will cover their costs. At any one time, the healthy members of the pool are helping to pay for the health-care costs of those who are ill; those who are healthy and those who are ill will change over time. The risk of falling ill and incurring unexpected and high health-care costs is shared between those in the pool.[36]

Universal coverage can 'in theory' be achieved through a combination of different financing mechanisms within one country, where different groups are covered by different mechanisms but all are 'adequately' covered in some way. However, it is increasingly being recognised that universal coverage cannot exist in systems with fragmented risk pools which do not allow for income and risk cross-subsidies (from the rich to the poor and the healthy to the ill) in the overall health system. These cross-subsidies are critical to achieve an equitable, efficient and sustainable health care financing system. As indicated previously, universal health systems are built on the principles of contributing to funding according to one's ability to pay and receiving health services according to one's need for care. As noted by the WHO, "[t]here is growing consensus that, other things being equal, systems in which the degree of risk-pooling is greater, achieve more".[37]

Countries which have considerable fragmentation of risk pools, such as the USA that has a large number of PHI schemes and two government-funded schemes to cover the poor and the elderly (Medicaid and Medicare), have been unable to achieve universal coverage. About 28% of adults (50 million Americans) were either completely uninsured or uninsured for part of the year in 2007.[38] In America, if one is uninsured one has very limited access to health care.

Some countries have achieved widespread population coverage through making membership of an insurance scheme compulsory, but there are a number of schemes from which they can choose, such as in the Netherlands. One drawback of this approach is the high administrative costs involved in having a number of separate schemes and the high marketing costs incurred as schemes compete for members. More importantly, there are often problems with achieving income and risk cross-subsidies across the different schemes. Indeed it is for these and other reasons that in 2000 South Korea, which has a long-standing mandatory health insurance system operating via smaller schemes, 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.

In other countries all citizens have access to some form of health care, but there are completely separate risk pools for different sections of the population resulting in a tiered health system (i.e. there are no income and risk cross-subsidies between the separate pools). This is particularly the case where there is a mandatory or social health insurance scheme covering only those working in the formal sector and general tax-revenue funded health services covering the rest of the population, as exists in Mexico and many other Latin American countries.[39]

Some argue that a tiered system is the only way to move towards a universal health care system based on the fact that, historically, most universal mandatory insurance schemes have begun by covering only formal sector employees and then attempting to expand coverage gradually. However, simply because this is the route that has been historically adopted by some countries does not mean that it is the only way to achieve universal coverage. Indeed, creating a two tier system can become an obstacle to achieving a universal system which includes comprehensive income and risk cross-subsidies. This has certainly been the experience of a number of Latin American countries that initiated mandatory insurance schemes by covering formal sector workers and their dependants and where this group has remained the focus of mandatory insurance initiatives for many decades. These countries have found that a two-tier health system has become entrenched and have encountered considerable difficulties in extending coverage, not least of all because the vocal and powerful formally employed groups have opposed moves towards universal coverage for fear of losing their preferential benefits.[40]

In recent times, a number of countries have introduced universal health systems with an integrated funding pool from the outset, such as Moldova and Kyrgyzstan. In these countries, a mandatory health insurance fund (MHIF) has been established into which mandatory payroll contributions by formal sector employees and general tax funds have been combined. The general tax funds are essentially seen as contributions by all of those outside of the formal sector. The local offices of the MHIF then purchases care for the entire population living

in their area. The majority of the funds (about two-thirds) come from general tax revenues and about one-third from payroll contributions.[18,41]

Purchasing

Purchasing relates to transferring the funds from the risk pool(s) to health-care providers and includes considerations such as the type of services covered (known as the benefit package) and the provider payment mechanisms. There has been some confusion about the concept of purchasing in that some people associate it only with health insurance schemes. However, purchasing is essentially about ensuring that appropriate, efficient, quality services are available to the population. It is equivalent to the better known concept of health service planning (i.e. assessing the health needs of the population to be served, determining what range and quantity of services are required and directing funds to these services). Active purchasing is absolutely critical for achieving universal coverage; it is of no value for citizens to have a 'paper entitlement' to health care if the purchasing function fails to deliver accessible, quality care of the type needed.

There is a great variation in the design of benefit packages across different countries. One of the key questions considered in benefit package design is should the package only include low-frequency, high-cost services, such as inpatient hospital care and long-term, terminal illnesses, which are often regarded as 'catastrophic events'? Or should it only cover high-frequency, low-cost services, such as acute and chronic care that can be provided at the primary care level? Or should it cover both types of services? Given the central goal of providing financial protection, many believe that the emphasis should be on protecting individuals and households from 'catastrophic' expenditure, which has traditionally been associated with inpatient care and other high-cost, low-frequency services. However, it is becoming increasingly clear that even small payments for primary care services can have catastrophic consequences for vulnerable households and that essential primary health care services should, therefore, be covered in countries with high poverty levels.[42] The design of a benefit package clearly depends on what people in a given country can afford, but a reasonably comprehensive benefit package is best able to protect households from catastrophic health-care costs.

In addition, cost-containment may be a problem if the benefit package only covers hospital services. If primary care services are not included in the package, patients tend to go directly to a hospital or a medical specialist for a health problem that could have been dealt with at the primary care level at a much lower cost. Many countries have found that having primary health-care providers act as gatekeepers to hospital care is a useful cost-containment mechanism.[43] If one is to avoid out-of-pocket payments that, as highlighted earlier, are regressive and a barrier to access, particularly for the lowest income group, active gate-keeping is essential. The major reason why some countries impose co-payments or user fees is to contain costs and reduce the potential for moral hazard[e] amongst the covered population. However, as noted by Kutzin, "[a]lthough 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".[44]

Middle-income countries that have achieved universal coverage despite having very constrained economic resources, such as Thailand, have adopted comprehensive benefit packages (ranging from primary to tertiary level services) but have adopted 'negative lists', i.e. a list of services that are explicitly excluded. The kinds of services most frequently included in 'negative lists' are entirely discretionary services (such as cosmetic surgery) and very high-cost services (such as dialysis for end-stage renal disease and organ transplantation). Thailand also has a very strong gate-keeping process with insistence on following the appropriate referral route, starting at the primary care level, and requires no co-payments or fees.

There is even greater variation across countries in terms of the type of provider payment mechanisms that are used. There is no one provider payment mechanism that is clearly 'better' than others; each has its advantages and disadvantages. However, one issue on which there is consensus is that unrestricted fee-for-service payment (i.e. itemised fees for each service provided) as the sole or main payment mechanism is unsustainable.[20,45,46] Most countries are adopting a combination of payment mechanisms that will ensure suitable incentives for health-care providers to deliver the appropriate type of services and to provide these services efficiently and at an acceptable level of quality.

Implications for the South African health system

The key message from the review of international experience is that South Africa's proposed health system reform is very much in line with prevailing international consensus. In particular, the goal of achieving universal coverage is firmly at the top of the global health policy agenda. Given that no government policy document has been released to date, it is difficult to accurately assess the extent to which proposed health system changes are in line with the current conven-

e Moral hazard is the tendency of entitlement to the benefits of health insurance to act as a strong incentive for people to consume more and 'better' health care and a weak incentive for them to maintain a healthy lifestyle.

tional wisdom. Public statements by the Minister of Health and the ANC suggest, however, that the broad policy direction is in line with what could be described as international 'good practice'.

In relation to revenue collection, the proposal is that funds will be mainly derived from general tax revenue but will probably be supplemented by some form of mandatory payroll contribution by formal sector workers. As indicated previously, general tax revenue is usually the most progressive source of funding. Any mandatory payroll contribution should be carefully structured to ensure that it is not regressive, drawing on lessons from international experience (e.g. not allowing people to 'opt out' of the mandatory contribution and not placing a cap or maximum limit on mandatory contributions).

There has been considerable media debate about the future role of medical schemes. It appears that medical schemes will continue to exist, but contributions to these schemes would be over and above a person's mandatory payroll contribution. In effect, medical schemes would provide supplementary cover (as exists in countries such as the UK), which again is in line with 'good practice' lessons from international experience.

Another aspect of revenue collection that is in line with lessons from international experience is the commitment to services being free at the point of service and not to rely on out-of-pocket payments as a funding source. Thus, co-payments will not be used as a mechanism for limiting health service use (see later discussion of gate-keeping to promote affordability and sustainability).

In terms of pooling, it is clear that there will be a single or integrated risk pool. For example, it was stated in ANC Today:

> 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.[47]

Having an integrated pool of funds is of considerable importance in relation to addressing the greatest challenge in South Africa in relation to achieving universal coverage, namely the breadth of coverage. As indicated previously, the challenge is to ensure that all South Africans are able to access health care when needed. There are a number of issues that underlie this challenge, such as being able to attract health professionals to work in remote rural areas, ensuring that there is a reliable supply of medicines to health facilities and addressing low staff morale in public sector health facilities. Another key factor is that South Africa currently has a divided health system with the majority of the most highly skilled health professionals working in the private health sector and being accessible only to a minority of the population.[f] An integrated pool of funds, which is larger than that currently made available to the public health sector through general tax revenue, will make it feasible to purchase services from both public and private health service providers to benefit all South Africans.

There are somewhat limited details on the proposed purchasing arrangements for the reformed health sector. It has been indicated, however, that:

> 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 at the primary health care level before referrals to specialists and hospital-based care when necessary.[47]

It has also been indicated that fee-for-service will not be the main provider payment mechanism but, instead, the emphasis will be on payment mechanisms such as capitation.[g] Finally, it has been stated that services will be purchased from both private and public health-care providers which, as indicated previously, is of considerable importance in the South African context for improving the breadth of coverage.

Although the broad policy proposals for health system reform that are publicly known appear to be in line with international trends, considerably more detail on the precise design of different elements of the health care financing system is required before conclusive judgements can be drawn. The design of a reformed health system is critical for the system to be affordable and sustainable.

The most heated aspect of the media debate has been about the affordability of the proposed reforms. As indicated previously, it seems premature to declare the reforms to be unaffordable before details of the proposed system design have been finalised. It is not the universality of a universal health system that makes it unaffordable, it is inappropriate design of a health system that can make it unaffordable.

There is no doubt that South Africa can have an affordable universal health system, in the sense of having vastly improved depth, height and particularly breadth of coverage than it has at present. Based on lessons from international experience, the key elements that are required to ensure an affordable and sustainable universal health system include the following:

- An integrated pool of funds that will tilt the power balance in establishing service payment levels in favour of the purchasing organisation as opposed to the providers;

f While there is considerable debate over the exact public-private mix of doctors and other health professionals, due to the unavailability of reliable data, there is no dispute over the fact that the majority of doctors, pharmacists, psychologists etc. work in the private health sector.

g Payment of an agreed amount of money per capita or per person, which may be adjusted for the relative risk of that person needing health care.

- Careful delineation of roles and responsibilities between the proposed NHI Fund and the national and provincial health departments to avoid duplication of management responsibilities and to minimise administration costs;
- Active purchasing of services to promote efficient and equitable provision of appropriate services;
- A benefit package that includes primary care services as well as specialist and inpatient care, with substantial attention being paid to ensuring that the focus is not solely on curative care but also includes preventive, promotive and rehabilitative services. Primary level care should be excellent so that individuals are confident that they will be adequately cared for if they follow the appropriate referral route and comply with gate-keeping by primary care providers; and
- Provider payment mechanisms that do not rely largely on fee-for-service payments but are carefully designed to provide incentives for efficient, good quality health service provision.

Universal coverage and achieving the MDGs

Pursuing a universal health system is very likely to contribute to more rapid progress towards the MDGs. The health system itself is not the only, nor is it necessarily the most important, contributor to improvements in health status. The social determinants of health are widely recognised. How then would pursuing a universal health system contribute to achieving the MDGs?

It is important to recognise that the benefits of a universal health system will not only be through direct impacts on health status improvements through ensuring greater breadth of coverage (so that South Africans can access needed health care), but there will also be considerable indirect benefits. For example, pursuing universal coverage will promote social solidarity and can contribute to addressing some of the power imbalances in society which contribute to ill-health. In addition, a firm commitment by government to universalism could translate into improved public funding for a range of social services, not only health services but also education, social welfare and other services that are critical for addressing the key social determinants of health and could reduce the demand for services from the NHI.

Finally, a universal health system by definition provides good financial protection against the cost of using health services. Not only does this contribute directly to reducing poverty, which is itself a key MDG, but will indirectly contribute to promoting health status improvements – given that poverty is a key social determinant of health.

Conclusions

The resolution of the ANC at its Polokwane policy conference to implement a NHI signalled its intention to pursue a universal health system. It is a great tragedy that South Africa did not implement the Gluckman Commission recommendations in the mid-1940s. We would not be faced with the health or health system challenges that we face today if Gluckman's vision had been acted upon. Almost seven decades later we have a window of opportunity to pursue a universal health system that will contribute in many direct and indirect ways to moving closer towards the MDGs.

However, we run the very real risk of once again losing a window of opportunity. Some of the ways in which we can contribute to seizing this opportunity include:

- Engaging in constructive and evidence-informed debate across stakeholders to reach greater consensus on what a universal health system entails and achieve broad-based commitment to universal coverage in pursuit of improved health for all South Africans;
- Careful development of an appropriate design for the proposed reforms to ensure that a universal health system is sustainable and affordable – allowing adequate time to undertake this task properly;
- Providing information to South Africans on the intended reform by initiating a process of widespread engagement with stakeholders around the policy proposals once they are placed in the public domain. Two groups whose views are critical but have not yet been heard in the ongoing media debate are:
  - The 'general public' who are the intended beneficiaries of the health system reforms; and
  - Front-line health workers, who will be expected to work in the reformed health system and indeed implement the proposed reforms – much of the problems with staff morale in the public health sector stem from the imposition of substantive reforms over the past decade or more without engagement or forewarning.[48]

South Africans have for too long tolerated a divided, inequitable and inefficient health system. There is no doubt that health system change is needed. The time has come for all stakeholders to work together to identify and pursue health system reforms that will benefit all South Africans through extending the breadth, depth and height of coverage of the country's health service.

Acknowledgements

The author is supported by the South African Research Chair's Initiative of the Department of Science and Technology and the National Research Foundation.

References

1 Second Report of the Commission on Old Age Pensions and National Insurance. (UG 50/1928). Pretoria: Government Printer; 1928.

2 Report of the Departmental Committee of Enquiry on the Subject of National Health Insurance (UG 41/1936) (Collie Committee). Pretoria: Government Printer; 1936.

3 Report of the National Health Services Commission (UG 30/1944) (Gluckman Commission). Pretoria: Government Printer; 1944.

4 Gluckman H. Abiding Values. Johannesburg: Caxton Press; 1971.

5 van Rensburg H, Harrison D. History of Health Policy. In: Harrison D, Nielson M, editors. South African Health Review 1995. Durban: Health Systems Trust; 1995.
URL: http://www.hst.org.za/uploads/files/sahr95.pdf

6 Benatar S. Letter: A national health service in South Africa. S Afri Med J. 1985; 68:839.

7 Coovadia H, Seedat Y, Philpott R, Loening W, Sarkin T, Ross S. Letter: A national health service for South Africa. S Afri Med J. 1986; 69:280.

8 Centre for the Study of Health Policy. A National Health Service for South Africa. Part I: The Case for Change. Johannesburg: Centre for the Study of Health Policy; 1988.

9 Owen C, editor. Towards a National Health Service: Proceedings of the 1987 NAMDA Annual Conference. Cape Town: NAMDA Publications; 1988.

10 de Beer C, Broomberg J. Financing health care for all – is national health insurance the first step? S Afr Med J. 1990; 78:144-7.

11 African National Congress. A National Health Plan for South Africa. Johannesburg: African National Congress; 1994.

12 Restructuring the National Health System for Universal Primary Health Care: Report of the Committee of Inquiry into a National Health Insurance System (Broomberg, Shisana Committee). Pretoria: National Department of Health; 1995.

13 National Department of Health. Report of the Health Care Finance Committee to the Minister of Health. Pretoria: National Department of Health; 1994.

14 National Department of Health. A Social Health Insurance Scheme for South Africa. A Policy Document. Pretoria: National Department of Health; 1997.

15 Department of Social Development. Transforming the Present – Protecting the Future: Consolidated Report. Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa. Pretoria: Department of Social Development; 2002.

16 McIntyre D, van den Heever A. Social or National Health Insurance. In: Harrison S, Bhana R, Ntuli A, editors. South African Health Review 2007. Durban: Health Systems Trust; 2007.
URL: http://www.hst.org.za/uploads/files/chap5_07.pdf

17 African National Congress. ANC 52nd National Conference Resolutions. 2007 Dec 16-20, Polokwane.

18 Kutzin J. Current Reforms Aiming at the Extension of Social Protection in Health: Linking up Mixed Health Financing Sub-Systems. In: ILO GTZ and WHO, editors. Extending Social Protection in Health: Developing Countries' Experiences, Lessons Learnt and Recommendations. Eschborn: Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ); 2007.

19 World Health Assembly. Resolution on Sustainable Health Financing, Universal Coverage and Social Health Insurance; 2005.

20 Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy. 2001; 56:171-204.

21 World Health Organization. The World Health Report 2000. Health Systems: Improving Performance. Geneva: World Health Organization; 2000.

22 Carrin G, James C. Reaching universal coverage via social health insurance: key design features in the transition period. Discussion Paper Number 2 - 2004. Geneva: World Health Organization; 2004.

23 Mathauer I. Designing Health Financing Systems for Universal Coverage – The Role of Institutions and Organizations. Universal Coverage Beyond the Numbers Seminar; 2009 Nov 26. Brussels: World Health Organization; 2009.

24 McIntyre D, Okorafor O, Ataguba J, Govender V, Goudge J, Harris B, et al. Health Care Access and Utilisation, the Burden of Out-of-Pocket Payments and Perceptions of the Health System: Findings of a National Household Survey. Cape Town: Health Economics Unit; 2008.

25 Goudge J, Gilson L, Russell S, Gumede T, Mills A. The household costs of health care in rural South Africa with free public primary care and hospital exemptions for the poor. Trop Med Int Health. 2009; 14(4):458-67.

26 Nkosi M, Govender V, Erasmus E, Gilson L. Investigating the Role of Power and Institutions in Hospital-Level Implementation of Equity-Oriented Policies. CREHS Research Report. University of the Witwatersrand: Centre for Health Policy, University of Cape Town: Health Economics Unit; 2007.

27 McIntyre D, Thiede M, Nkosi M, Mutyambizi V, Castillo-Riquelme M, Gilson L, et al. A Critical Analysis of the Current South African Health System. University of Cape Town: Health Economics Unit, University of the Witwatersrand: Centre for Health Policy; 2007.

28 McIntyre D. Private sector involvement in the funding and provision of health services in South Africa: Implications for equity and access to health care. Equinet Discussion Paper Series 84. University of Cape Town: Health Economics Unit; 2010.

29 van den Heever AM. Evaluation of the Merger between Network Healthcare Holdings and Community Healthcare. Pretoria: Council for Medical Schemes; 2007.

30 McIntyre D, Thiede M, Birch S. Access as a policy-relevant concept in low- and middle-income countries. Health Econ Policy Law. 2009; 4:179-93.

31 McIntyre D. Learning from Experience: Health Care Financing in Low- and Middle-Income Countries. Geneva: Global Forum for Health Research; 2007.

32 McIntyre D, Kutzin J. Revenue Collection and Pooling Arrangements in Health System Financing. In: Smith R, Hanson K, Palmer N, editors. Health Systems: A Political-Economy Perspective. Oxford: Oxford University Press.

33 Gottret P, Scheiber G. Health Financing Revisited: A Practitioner's Guide. Washington DC: The World Bank; 2006.

34 O'Donnell O, Van Doorslaer E, Rannan-Eliya RP, Somanathan A, Adhikari S, Akkazieva B, et al. Who pays for health care in Asia? J Health Econ. 2008; 27:460-75.

35 Wagstaff A, van Doorslaer E, van der Burg H, Calonge S, Christiansen T, Citoni G, et al. Equity in the finance of health care: some further international comparisons. J Health Econ. 1999; 18:263-90.

36 Normand C. Using social health insurance to meet policy goals. Soc Sci Med. 1999; 48:865-9.

37 Davies P, Carrin G. Risk-pooling – necessary but not sufficient? Bull World Health Organ. 2001; 79(7): 587.

38 Collins S, Kriss J, Doty M, Rustgi S. Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families. Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007. New York: The Commonwealth Fund; 2008.

39 Frenk J. Comprehensive policy analysis for health system reform. Health Policy. 1995; 32(3):257-77.

40 Ensor T. Transition to Universal Coverage in Developing Countries: An Overview. University of York: Centre for Health Economics; 2001.

41 Kutzin J, Shishkin S, Bryndová L, Schneider P, Hrobo P. Implementing Health Financing Reform: Lessons from Countries in Transition. Copenhagen: World Health Organization; 2010.

42 Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? Lancet. 2001; 358:833-6.

43 Ros C, Groenewegen PP, Delnoij DM. All rights reserved, or can we just copy? Cost sharing arrangements and characteristics of health care systems. Health Policy. 2000; 52(1): 1-13.

44 Kutzin J. Experience with organizational and financing reform of the health sector. SHS Current Concerns Paper Number 8. Geneva: World Health Organization; 1995.

45 Carrin G, Hanvoravongchai P. Health care cost-containment policies in high-income countries: how successful are monetary incentives? Discussion Paper Number 2-2002. Geneva: World Health Organization; 2002.

46 Langenbrunner J, Cashin C, O'Dougherty S, editors. Designing and implementing health care provider payment systems: How to manuals. Washington DC: The World Bank; 2009.

47 African National Congress. National Health Insurance: A revolution in healthcare. ANC Today. Johannesburg: African National Congress. 2009 Jan 23-29, 9(3).

48 McIntyre D, Klugman B. The human face of decentralisation and integration of health services: Experience from South Africa. Repro Health Matters. 2003; 11(21): 108-19.