Financing South Africa's national health system through national health insurance

POSSIBILITIES AND CHALLENGES

COLLOQUIUM PROCEEDINGS

Compiled by Claire Botha and Michael Hendricks

HSRC POLICY ANALYSIS UNIT

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Acronyms

ANC	African National Congress
BHCP	basic healthcare package
CSSS	comprehensive system of social security
DHS	district health system
GDP	gross domestic product
GEMS	Government Employees Medical Scheme
HSRC	Human Sciences Research Council
MHC	managed healthcare
MOST	Management of Social Transformation programme (at UNESCO)
NHI	national health insurance
NHS	national health system
PAU	Policy Analysis Unit
RDP	Reconstruction and Development Programme
REF	risk equalisation fund
SAHRC	South African Human Rights Commission
SASSA	South African Social Security Agency
SARS	South African Revenue Service
SHI	social health insurance
SSMS	state-sponsored medical scheme
UIF	Unemployment Insurance Fund
UNESCO	United Nations Education, Scientific and Cultural Organization

Preface

This report contains key presentations and a summary of deliberations from a colloquium on 'Health within a comprehensive system of social security', hosted by the Policy Analysis Unit of the Human Sciences Research Council (HSRC) from 31 July to 2 August 2007. The colloquium brought together a range of stakeholders – including policy makers, health practitioners, members of parliament, academics, health professional councils and regulatory bodies, the Board of Healthcare Funders, non-governmental and civil society organisations, and policy analysts – to present, deliberate and engage on key policy issues and potential options in pursuit of a national health system (NHS) as envisaged within the national health plan of the African National Congress (ANC) (see List of participants). The colloquium was the first step in a process of canvassing views to facilitate constructive stakeholder participation and active debate on the subject.

The colloquium was hosted by the HSRC under the auspices of the South African National Liaison Committee of the Management of Social Transformation (MOST) programme at the United Nations Education, Scientific and Cultural Organization (UNESCO). The main purpose of the colloquium was to initiate policy dialogue and critical discussions on how health services are accessed, provided and funded – and to formulate ideas, views and recommendations that could be presented to those involved in health policy development.

The colloquium was structured around four key themes with interactive presentations and discussions by various speakers. The colloquium addressed the following key themes, with presentations organised across themes to promote interactive debate:

- Trajectory for a future NHS: the reform path since 1994
- Critical options for health within the context of a comprehensive system of social security
- Local and international evidence on health system models
- Health systems reform and stakeholder engagement.

Section A of the report contains the opening speech by Dr Olive Shisana, CEO of the HSRC, and the keynote address by the Honourable Minister of Health, Dr Manto Tshabalala-Msimang, followed by a discussion of the context for

policy debates on health within a comprehensive system of social security. Section B of the report provides a synthesis of colloquium proceedings, beginning with a brief summary of inputs and discussions under the four key themes. The section concludes with a brief outline of key issues discussed in the areas of healthcare provision, healthcare funding and the purchasing of healthcare. Section C of the report provides recommendations for improving implementation, and taking forward the process of policy development towards an NHS.

Introduction

Claire Botha

The development of a national health system (NHS) has been central to proposals for the restructuring of the health sector since 1994. Based on the tenets of the ANC's 1994 national health plan (ANC, 1994), South Africa's health system has witnessed a number of policy interventions aimed at advancing the policy agenda of an NHS. Considerable progress has been made in terms of laying the foundation for such a system in relation to the delivery, organisation and funding of health services.

Firstly, access to healthcare became an entrenched right with government responsible for providing the conditions to achieve this. Thus within a rights based-constitution every person in South Africa has the right to achieve optimal healthcare. Secondly, access to primary healthcare services has increased significantly with 20 million more patient visits annually compared to five years ago (NDoH 2007). The number of annual visits per person to a healthcare facility increased from a mere 1.8 per person in 1998 to 2.1 in 2004 (NDoH 2007). Thirdly, the number of health personnel (doctors, nurses, pharmacists, ambulance personnel) serving rural communities increased by 31 710 since 2004, due to the implementation of the scarce skills and rural allowance strategy, with the related geographic redistribution of health professionals through the implementation of the Community Health Service programme (NDoH 2007). Fourthly, since 2004/05, public hospital reform, still underway, saw in excess of 40 hospitals rehabilitated through the hospital revitalisation programme. Fifthly, many elements of the district health system (DHS) have been implemented such as alignment of health district boundaries with municipal district boundaries, organisation of district health services and the establishment of a referral system. The DHS governance and a coherent funding framework still need to be finalised. Finally, in terms of the 2003 Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment and its successor, the National Strategic Plan 2007–2011, significant progress has been made towards providing access to treatment

and care. As of 2007, the public health system has at least 260 000 people on treatment at 313 sites across 53 health districts (NDoH 2007).

Despite considerable progress, key failures of the public health system are pervasive. Notwithstanding the implementation of a number of well-documented policies, the public health system is still afflicted by the challenges of inadequate and inequitable access to health services attributable to delivery inefficiencies, poor quality care, under-funding and the remaining lack of social solidarity within the system.

Post-apartheid South Africa inherited a dual health system[1] that has been perpetuated into the present day, and continues to undermine progress made towards the transformation agenda of an NHS (NDoH 2007). As evidenced during the South African Human Rights Commission's (SAHRC) public hearings into the right of access to healthcare, words such as accessibility, equity and efficiency to healthcare remain mere aphorisms for millions of South Africans in dispersed or impoverished communities without any health cover (Ntuli 2007). It is no longer acceptable for current failures of the healthcare system and inequities in access to public healthcare to be blamed on the legacy of apartheid. As the SAHRC cautioned during these hearings, such failures could erode entrenched constitutional rights (Ntuli 2007).

Many argue that these challenges are nested in the dualist structure of the South African health system, with disparities in the public-private sector and the nature of the interface, or lack thereof, serving as major impediments to an equitable and sustainable health system. These embedded public-private inequities combine to undermine people's right to optimal healthcare. The inability to effect a relative redistribution of resources 'locked in' the private sector to ensure equity of the health system as a whole gives rise to a highly unequal and polarised health system. This is hampering the fulfilment of the constitutional imperative for the 'progressive realisation' of the right to healthcare.

Towards a relative alternative

South Africa's dual healthcare system is characterised by a number of features. Firstly, the funding system is distinguished by public sector funding through national taxes and donations from various sources, and a significant

private sector with medical schemes as the predominant social insurance mechanism for accessing health services. Health services are also funded by social insurance schemes through government-sponsored arrangements, for example the Road Accident Fund, Compensation for Accidents and Injuries and Medical Schemes (Committee of Inquiry into a System of Comprehensive Social Security 2002). Social security reforms underway are meant to reverse this uncoordinated and fragmented funding of healthcare. Other government departments and parastatals that also fund healthcare services are, for example, the National Defence Force and the South African Correctional Services.

Approximately R135 billion (or 8%) of South Africa's GDP is spent on healthcare through various financial intermediaries and government, with this cost projected to grow (National Treasury, personal communication). A significant portion of this, 5%, is spent in the private sector through medical schemes. South Africa currently spends approximately 11% of its total budget on health services, falling short of the Abuja Declaration's proposed spending of 15% for governments within the African Union.[2]

An already overburdened public sector and provider of last resort caters for approximately 85% of the population on a health budget of less than 44% of the total health expenditure. Stagnant public sector health expenditure is attributable to limited funding and declining budget allocations to government's financial intermediaries (provincial and local government departments). This is not keeping pace with the increasing proportion of the population becoming dependent on the public sector through population growth, declining medical scheme membership and disease burden (Committee of Inquiry into a Comprehensive System of Social Security for South Africa 2002: 86) Meanwhile, a shrinking but well-entrenched private sector – with a guaranteed clientele and heavily subsidised (directly and indirectly) by the government – is left to consume the bulk of financial resources (in excess of 55%) for the benefit of middle-to-high-income earners regardless of race, constituting approximately 11% of the population (recent estimates by Finscope suggest 8%). The private sector is over-resourced and underutilised. Direct and indirect subsidies relate to tax exemptions on medical scheme contributions and the subsidised training of healthcare workers, who upon completion of training end up practising in the private sector. South Africa's unequal and highly polarised healthcare

system is fuelled by – if not rooted entirely in – the funding arrangements for healthcare, giving rise to overwhelming challenges.

A lack of critical distinction between the public and the private health sectors and what they represent has allowed the claim to be made that South African healthcare expenditure levels compare favourably with international standards (Chetty 2007). International experience shows that private health insurance tends to flourish in countries with widely differing income levels and health system structures (Sekhri & Savedoff 2006) – and South Africa is no exception. The public and private sectors in South Africa are of equivalent size in terms of overall expenditure, but cover substantially different population sizes. A recent study demonstrated starkly the uneven expenditure across the public and private sectors relative to population served, with government spending up to 12 times more per civil servant in the form of medical schemes contributions than per person dependent on the public sector (McIntyre et al. 2003). Thus per capita expenditure has been increasing more rapidly in the private sector than in the public sector.

Medical scheme coverage from 1996 to 2003 in terms of race declined significantly from 18.1% in 1996 to 11.0% in 2003 (Shisana et al. 2006). The practice within the medical schemes environment, where health coverage is linked to employment and where benefits are linked to income and ability to pay, undermines the principle of equal care for equal need. There is ample evidence to suggest that even where healthcare is available for those on private health insurance, the near-poor often forego the care they need because it is unaffordable due to increased out-of-pocket payments. The increasing costs have led to a decline in private cover membership which in turn has led to smaller and often fragmented risk pools (Shisana et al. 2006). Surging healthcare costs (cost increases due to medical inflation which is significantly higher than the overall consumer price index), weak cost control and poor risk selection are resulting in a shrinking number of South Africans able to afford private healthcare, and declining medical scheme coverage, leaving an even greater majority of the population without access to private sector healthcare, and thus increasing the burden to the public sector. The current debate on cost escalation in the private sector seems to be simplistic and narrowly focused, and lacks a clear articulation on the real nature and extent of the costs faced by the private sector.

In the environment where the private sector, operating in a weak regulatory context, is inclined towards excessive cost inflation while locked into a system offering declining benefits, the consumer has come to bear an increasing portion of the financial burden. In an effort to control surging healthcare costs, the private sector has turned to managed healthcare (MHC) which, although well intentioned, has had the unintended consequences of dumping patients onto the public sector even sooner as private health cover benefits have been exhausted. Although consumers reliant on private health insurance might come across as indifferent, their silence should not be interpreted as complacency, especially since premiums paid to medical schemes are often the highest or second highest expense item on their payslips.

Despite this context, the government has reached the unavoidable conclusion that the private sector has to play some role in ensuring that equity, access and efficiency objectives are achieved for the health system as a whole (Herman et al. 2000). However, the private sector is some way off from taking on this responsibility. Some might argue that the industry is gradually moving in the direction of low-cost and affordable cover with the low income medical schemes' options and prescribed minimum benefits (including the chronic diseases list). But, in fact, the attempt at self-regulation has resulted in increasing costs, instability and volatility.

The industry has seen a number of government interventions aimed at curbing runaway healthcare costs and optimising the public-private sector interface. Examples include reforms to tax subsidy and single-exit pricing of medication, Certificate of Need regulation (not yet law, so not implemented), National Health Reference Price List and the Health Charter (DoH n.d., not yet signed, so not implemented). But these have had little impact on reducing costs and broadening access.

It has been argued that MHC per se seems unlikely to compromise equity, quality of care or the public healthcare sector, and that it may potentially promote national health policy objectives (Herman et al. 2000). However, if the benefits of MHC are to be maximised and potential negative effects controlled, ongoing monitoring of MHC, coupled with an appropriate regulatory and incentive environment, will be required (Herman et al. 2000).

The skewed distribution of resources mirrors expenditure patterns. Consequently, an over-resourced (in terms of human and material means)

and under-utilised private sector is coexisting alongside a public sector characterised by declining health budgets, a growing burden of disease due to the HIV/AIDS pandemic, worsening health status indicators, the resurgence of communicable diseases and inadequate human resource provisioning (NDoH 2007). These overwhelming challenges have been exacerbated by marked differences in health professional density between the public and private sector, and urban and rural areas in the public sector (Sanders & Lloyd 2005). The latter can in part be attributed to the apartheid system of training health professionals. For example, by the end of the 1990s, 75–77% of specialist, 50–70% of general practitioners and approximately 40% of nurses worked in the private sector, biased towards the urban sector (McIntyre et al. 2003).

Health services are resource dependent and, given the mounting challenges of both financial and human resource concentration in the private sector, low staff morale in the public sector, with queuing and poor service quality at point of service at public health facilities a common occurrence, there is a need for an alternative. Against this backdrop, it is not disputed that South Africa's highly polarised healthcare system is in need of refocused attention and support to ensure a unified system with a greater redistributive impact; much debated is how to reduce social exclusion within the context of the country's comprehensive system of social protection. So what is the relative alternative?

Notes

1 Health system is conceived in terms of the World Health Organization's definition with reference to all the activities whose primary purpose is to promote, restore or maintain health

2 Abuja Summit to endorse Africa Development Forum 2000 Consensus on fighting HIV/AIDS. http://www.uneca.org/ADF2000/Abuja%20Declaration.htm (accessed 3 December 2007)

Section A
Key speeches and setting the context

A national health system: opportunities and challenges for South Africa

Opening address by Dr Olive Shisana, Chief Executive Officer, HSRC

Enshrined in the South African Constitution is that every person has the right to achieve optimal health. It is the responsibility of the government to provide the conditions to achieve this. Some might contend that this right is presently not equally enjoyed by all, that it is limited to what economist John Kenneth Galbraith has called 'the affluent society'. Much like Galbraith's interrogation of American society in the aftermath of World War II, South Africans have been looking at ways to undo some of the apartheid system's hangovers post-1994. The health system has not been immune to apartheid's infections, and 13 years down the line we are still witnessing how the private sector is becoming wealthier whilst the public heath sector remains stagnated, largely lacking the necessary human and financial resources to provide good quality care to those who seek its services.

Granted, considerable progress has been made since 1994. This principally speaks to the establishment of a national health system (NHS), as called for in a number of policy documents (for example, the ANC Health Plan and the Reconstruction and Development Programme). We have also noted the lingering legacy of the past, as featured at the public hearings held by the South African Human Rights Commission (Public Inquiry into the Right to Have Access to Healthcare Services), warning of the ever-eroding constitutional requirement of 'access to health for all'.

The agenda for post-apartheid South Africa's health policy is outlined in the ANC's national health plan (ANC 1994), in which the need for an NHS is expressed and clearly articulated. Moves towards the establishment of an NHS commenced in 1994, with an overhaul of the entire system – looking at both the provision and funding of healthcare. Since then, as part of the health system's reform agenda, various committees were set up to investigate proposals on a future health system that would inform policy direction to ensure 'access to health for all'. Government's initial proposal for national health insurance (NHI) drew criticisms for being too costly and rigid, mainly from National

Treasury and health professionals. The 1994 Committee of Inquiry into National Health Insurance System and the follow-up 1997 Committee to further investigate improved access to healthcare were established. The former argued strongly for an NHI system – and some of its recommendations were implemented by prioritising primary healthcare and instituting reforms to the medical schemes' environment as a vehicle towards a future NHS.

However, the 1994 Committee of Inquiry's recommendations fell short of promoting a system of 'access to health for all'. These were thus revised by the 1997 Committee, which argued for a phased approach towards ensuring 'access to health for all' by means of social health insurance (SHI) with the NHI seen as a second step.

Unfortunately, the results of these policies, devoid of a consensus approach to addressing challenges in the health system, further exacerbated inequities; more people who had medical aid have since lost it. Consequently, more people than before now rely on the public health system or are forced to use the public sector because they cannot afford the cost of medical aid. Premature exhaustion of benefits results in them either foregoing private healthcare or using the public health sector. There is therefore an urgent need to correct these unintended policy consequences.

Even though medical schemes are regulated, cost escalations have been significant, particularly in recent years. This points to the inadequacy of legislation in this regard, as well as the industry's inability to contain costs. This is partly the result of the fee for service environment in which the private health sector operates. Then, in 2000, Cabinet appointed a Committee of Inquiry into a Comprehensive System of Social Security for South Africa, which investigated how to secure and enhance social protection (the social protection concept being broader than the narrow focus on social security) for all South Africans. However, the implementation of the recommendations of this committee as related to health has been patchy. As they evolved, these policy debates were accompanied by quite a bit of background and history which ought to be taken into account as you deliberate on these policy issues.

Conventional wisdom holds that any health system pursuing 'access to health for all' should conform, as a minimum, to the following guiding principles: right to health; social solidarity; universality; vertical equity; universal access

to healthcare; and efficiency in resource use. These principles can be defined as follows:

- Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this.
- Social solidarity – the principle of 'social solidarity' in this context implies broader risk pooling and equitable benefits in exchange for contributions from those able to make payment, with the government contributing on behalf of the indigent. This should not exclude supplementary health insurance.
- Universality – compulsory membership is essential so as not to undermine the principle of social solidarity.
- Vertical equity (unequal treatment for unequal need) – acknowledges that 'unnecessary' or 'avoidable' gaps in health and healthcare service delivery between groups with different levels of social privilege should be eliminated (Whitehead 1992).
- Universal access to healthcare and related resources – this principle secures equality in access to a defined package of healthcare irrespective of whether it is publicly or privately funded. This principle calls for access to basic healthcare as articulated in the ANC Health Plan and expressed in the Reconstruction and Development Programme.
- Efficiency – pooling public and private resources (money, human resources, physical infrastructure, equipment, medicine) together to ensure sustainability.

Using these principles as a checklist: What should the role of the state be with regards to meeting these principles? How do we ensure broader risk pooling and equitable benefits in exchange for contributions from those able to pay, with the government contributing on behalf of the indigent? Is there a place and role for a supplementary health insurance?

An NHS premised on the above-mentioned principles:

- is in line with constitutional provisions;
- reduces disparities in access to good quality healthcare;
- helps contain cost of healthcare in the public and private sectors;
- addresses the unsustainability of the current system;
- eliminates subsidies for special interest;
- improves efficiency of the system;

- reduces social polarisation and ultimately improves the quality of life of all South Africans.

We are proposing that this colloquium consider and debate these principles and support their utilisation in guiding health policy debates in the context of a comprehensive system of social security. The ANC National Policy Conference, held at Gallagher Estate on 27–30 June 2007, affirmed the need for the implementation of the NHI system. Clearly, this is a prudent option to explore, amongst others, given the current inequitable distribution of resources for health and extreme challenges to accessing good quality services by the majority. Therefore, the real challenge is the establishment of an NHI system in which every South African, irrespective of socio-economic class, has an equal opportunity to be attended to in time of need.

An NHI system presents itself as an ideal mechanism for providing equitable access to quality health services in South Africa for the following reasons:

- It satisfies the fundamental principles of a unitary health system, as defined earlier, which are also enshrined in our Constitution.
- It promotes redistribution and sharing of healthcare resources between the public and private sectors and hence it meets our transformation agenda.
- Evidence from research suggests that South Africans are generally willing to contribute to a financing system that caters for them and those unable to contribute.

How is such a system to be established? In our view, this is achievable through a model NHI plan that draws in private and public health sector funds, and human and physical resources, to ensure that all South Africans receive the constitutional entitlement of access to healthcare free at the point of service. The financial contribution would come from employers, employees and the self-employed – with the government providing for the indigent. The contribution would be progressive, thus promoting vertical equity and the idea that one risk pool allows for cross-subsidisation between the poor and the rich, the healthy and the unhealthy. This could also include funds currently paid to medical aid schemes by government or public entities. Compulsory or mandatory contribution would ensure that the entire population is covered. The cover would be comprehensive in that people would have access to comprehensive healthcare services regardless of employment status. The services would continue to be provided by both public and private providers as currently the case but the health funds would be administered through a

single agency, such as the South African Social Security Agency (SASSA). The fund's administration costs could be set by Parliament.

A *single-payer model* is likely to result in significantly lower administrative and transactions costs and significant cross-subsidisation. The general world trend in purchasing functions reforms in health seems to be a movement away from fragmented and competitive environments. However, single-payer models require other mechanisms of ensuring that the single purchaser is accountable to the contributors because enrollees cannot vote with their feet. Admittedly, such structural and organisational reforms in health need to be supported by robust legislative changes that will make *contribution mandatory* for both formal and informal employees and employers, and govern the activities and conduct of both public and private providers.

An NHI plan would include all South Africa under one roof. Clinics, community hospitals, regional hospitals, specialised and tertiary hospitals would be organised in such a way that the package of services provided would be defined clearly through national norms and standards in terms of quality and quantity and people could use both the private and public sector facilities. Those who seek additional insurance cover can subscribe to a medical scheme, which would still exist under this plan, but only after they have contributed to a national effort. Such an arrangement would provide opportunities for the rich who might want to have more than the prescribed basic package services, for example, cosmetic surgery.

All medical practitioners under this scheme would be contracted to the NHI authority but could still supplement income by serving those who have 'top-up' insurance. All general practitioners (GPs) would be contracted to provide services to a defined number of patients in a defined area within the boundaries of the districts (through capitation contracts). This means that the responsibility for the health of the population in a defined community would be that of medical or primary care practitioners. Under this proposal, GPs would practise community health rather than just individualised medicine and could be given incentives to locate in previously disadvantaged areas. Further, more GPs would be able to effectively act as gatekeepers to the healthcare system and therefore improve allocative efficiency and reduce healthcare cost escalation due to over-use and self-referrals at inappropriate levels of the healthcare system.

Clearly, an NHI system would enable South Africa to ensure that the constitutional right of access to healthcare is attained, to help contain the cost of healthcare (in both the public and private health sectors), reduce disparities and inequities in access to healthcare and improve quality of life of many. The question that arises then is what structures and processes we need to ensure that the ANC resolution on NHI or a variant thereof is taken forward.

Our proposal is that a high-level implementation team be established at this colloquium to review previous recommendations and proposals over the past ten years regarding healthcare financing reforms and to develop a practical implementation plan for a favoured option, with clear time frames and deliverables. A political process as well as a technical process are vital in taking this initiative forward. As the HSRC and MOST, our job is to examine policy options using a scientific lens. I sincerely hope that the deliberations of this colloquium will not only enrich our understanding of health systems reforms but come up with concrete suggestion for achieving universal access to quality health services for all South Africans.

Health within a comprehensive system of social security: is national health insurance an appropriate response?

Keynote address by the Minister of Health, Dr Manto Tshabalala-Msimang

The question that is being addressed at this colloquium is whether or not national health insurance (NHI) could be an appropriate vehicle to achieve social solidarity within the healthcare system.[1]

This is not the first and last time that an NHI system is advanced for funding healthcare in this country. As you all might know, the NHI policy was adopted by the ANC prior to 1994, and was contained in the ANC Health Plan of May 1994 (ANC 1994). It guides the transformation of the health sector. The quest for universal coverage and improved efficiency of our health system was also discussed during the ANC Policy Conference in 2007. The ANC Policy Conference reaffirmed its commitment to an NHI.

In fact, in 1994 the ANC recommended the establishment of a Commission of Inquiry to look at the current crisis in the medical aid sector, and to consider alternatives such as a compulsory NHI if there is sufficient consensus on this option.

It was further requested that the Commission should consider a range of structural/institutional frameworks for the NHI – that is, a single state or parastatal NHI, a single privately administered NHI, or an NHI with the current medical aids acting as the financial intermediaries with pooling of contribution revenue for risk adjustment.

The Commission was specifically asked to investigate the feasibility of an NHI based on the following principles:

- The current medical schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system.
- Membership would be compulsory for all formal sector employees and their dependants.

- Schemes which form part of the NHI should be prohibited from excluding any member (for example, on the basis of high risk).
- The basic package of care to be covered by the NHI should be statutorily defined.
- Contribution to cover the basic package would be income related, probably determined centrally, and should be jointly paid by employers and employees.
- This contribution revenue (covering the basic package) should be pooled in a central equalisation fund, out of which every scheme would be paid in terms of its overall profile, that is, a risk-adjusted capitation fee.
- Existing health insurance companies and medical schemes would be free to offer 'top up' cover for services not covered in the NHI essential package.

The long-term goal would be for all citizens including the unemployed to be covered under the NHI system. The question to ask is what progress have we made and what more should be done to achieve universal coverage in the NHS?

The recommendations made by the Commission in 1995, and subsequent task teams that were formed to further take forward the reforms, were then translated into practice.

Medical schemes were re-engineered to support broad health policy objectives of making private healthcare affordable:

- Firstly, we re-established the notion of community rating to ensure that the principle of solidarity could be entrenched in the medical schemes environment.
- Secondly, we introduced open enrolment, to improve access to medical schemes for people who were previously excluded.
- Thirdly, we mandated a set of prescribed minimum benefits to ensure that members of medical schemes have adequate coverage.
- Fourthly, we introduced financial solvency and corporate governance to protect the interests of members.

We strongly felt that it would have been premature to introduce an SHI/NHI system under conditions of serious fragmentation and financial instability in the medical schemes market in particular, and the NHS in general.

The Medical Scheme Act of 1998 sought to promote access to affordable private healthcare for those who are able to pay for their healthcare. The

Act came into effect in 2000. At the same time, Cabinet also appointed a Committee of Inquiry into Various Aspects of the System of Social Security in South Africa.

The Committee released its report in 2003. For health, the Committee proposed that South Africa moves toward an NHI system over time that integrates the public sector, and medical schemes environment within the context of universal contributory system.

Subsequently, Cabinet adopted a Comprehensive Social Security Framework based on a pillar approach:

- Pillar 1 is intended to provide a universally available basic benefit for all citizens and specified classes of legal resident.
- Pillar 2 entrenches the contributory environment over and above Pillar 1, characterised by strong mechanisms to ensure social solidarity through income-based cross-subsidies, risk-related cross-subsidies and mandatory participation.
- Pillar 3 makes provision for the discretionary social security over and above minimum levels regarded as essential.

The challenge for us is to think carefully about how to achieve social solidarity for the health sector within this comprehensive social security framework.

You are all aware that solidarity is the crucial ethical and economic foundation for risk pooling and redistribution. The solidarity in healthcare financing is the general tax system and compulsory health insurance. Some countries (such as UK or Sweden) have chosen the tax route, while others (such as France, Germany or countries of Latin America) have chosen the insurance route.

Twenty-seven countries have chosen to achieve universal coverage via Social Health Insurance (SHI) policies, with varying speed of transition. It is important to point out that to achieve a national or social health insurance system is going to take us some time.

We all know that it took Germany close to 100 years to achieve an inclusive social health system. On the other hand, it took South Korea only 12 years to cover the whole population, including the poor, the unemployed and the self-employed, and this is a remarkable achievement.

We all have to understand that it will take time, too, in South Africa. However, experience elsewhere has shown that if the SHI framework is implemented carefully it could safeguard solidarity and universal coverage, as has been the case in 27 other countries.

This now brings me to the issue of terminology. I have noticed that the terms 'national health insurance' and 'social health insurance' are sometimes used loosely and (confusingly) interchangeably. My understanding is that *national health insurance* provides benefits for both contributors and non-contributors in a universal system whereas *social health insurance* benefits contributors only.

We are analysing whether there are any building blocks that can be put in place to make us move smoothly towards the NHI, either shortly, or in the long run. We therefore remain committed to an NHI system as the end goal. How we get there is still a subject for debate, which includes consideration of whether we can introduce SHI as a means of achieving that end goal.

In this country, such a system would comprise three elements:
- government-mandated health insurance covers for specified groups;
- income cross-subsidies among contributors; and
- risk-related cross-subsidies among contributors.

Government-mandated health insurance

We have learnt that most developed and some developing countries use compulsory health insurance contributions to finance their health services. The advantages of compulsory health insurance are widely documented and do not need further elaboration. However, what we are grappling with is whether to go with individual mandates or employer mandates, for example, employer mandates form the backbone of health systems in Europe, Latin America and Asia. The key question to ask is whether this should also form a backbone of health systems in Africa, particularly South Africa.

The government has taken an initiative through the Government Employees Medical Scheme (GEMS) to introduce these mandates. Contrary to this, an Old Mutual Health Survey has shown that companies are abdicating their responsibility with regard to the financing and provision of healthcare, which may make these mandates unachievable.

Nonetheless, in the short to medium term, we believe that medical schemes' contribution should be mandatory for those who can afford to make some contribution towards their healthcare. Obviously, the mandates will have to be effected in a systematic and a phased approach, starting with either high-income earners or specific groups of employers.

Income cross-subsidies among contributors

Income solidarity is deeply entrenched in most social insurance systems around the world. Statistics show that income inequality in South Africa, as measured by the Gini Coefficient, is at 0.59 when social transfers are excluded, but it declines to 0.35 when social transfers are included. Given that there are these huge income disparities in our country, it is of critical importance to incorporate income solidarity within the NHS.

Currently, medical schemes are *community rated* and not *income related*. There are therefore fewer income cross-subsidies under the existing market structure. The tax expenditure subsidy on medical schemes' deductions, despite their recent changes, are in no way close to encouraging income cross-subsidy and this still remains a fundamental flaw in the tax system.

Risk-related cross-subsidies among contributors

During the apartheid era, medical aid contributors were charged on the basis of one's medical history and health status. This led various groups of people, particularly the elderly and the chronically ill, to buy inappropriate and inadequate medical cover. We have eliminated such risk rating practices but perverse incentives still occur through cream skimming.

Cream skimming or risk selection occurs through the manner in which medical schemes design their benefit packages, which may be attractive to young and healthy people. This undesirable business practice results in risk splitting, weakening of risk pools and further undermining risk-related cross-subsidies from low-risk to high-risk individuals.

The establishment of a risk equalisation fund (REF), which will be fully operational in 2009, will aid to stabilise risk pooling in medical schemes and provide a vehicle for the implementation of SHI.

Discussion at this colloquium appears to signal that we may be trying to achieve solidarity by taking a longer route, that of SHI, rather than an NHI. It will be good to hear views from stakeholders on this matter. However, I must emphasise that our own discussions are not finished, and that is why we would like to enter this debate, lest we be interpreted as favouring one view against the other. The Department of Health introduced the SHI debate in government, and since then other debates have ensued and are still going on.

There are also issues related to the best vehicles for advancing the NHI system. Countries such as Germany, the Netherlands, Switzerland and Belgium have used medical schemes to advance their SHI system. Our experience here may be different precisely because:

- Almost every year, the medical schemes increase the contributions paid by members.
- There is an increase in non-healthcare costs – that is, administration, managed care and broker fees.
- There is also an increase in hospital and specialists' costs.
- There is no direct relationship between the quality of healthcare rendered and these increases.
- There is a decrease in the medicine costs but no decrease in the total cost of healthcare.

Equally we are considering questions such as whether a single-payer system as in France and the UK is the most appropriate and feasible approach for this country, and whether medical schemes would play a role once a single payer system is implemented.

I have listed these issues that are still in consideration by government in order to highlight the fact that we in the Department of Health take seriously our role as policy makers for this country. Government determines policy in the end. Stakeholders have different platforms to express their views and to try to influence government to move in one direction or the other. This is one of those platforms, and our view is that we are here to listen to suggestions and views we can take into consideration as we formulate the stance of the government, which we will ultimately take to Cabinet. We are therefore keen to hear what other stakeholders say, rather than express our views, which may prejudice whatever decisions we need to take in future.

I hope that the colloquium will address these issues so that we can move away from theory and begin to think about how the proposals would work in practice.

Note

1 The Minister's keynote address was delivered by Prof. Ronald Green-Thompson.

Setting the context

Claire Botha and Michael Hendricks

Prior to 1994 a national health insurance (NHI) scheme has always been advocated as the policy option to guide the transformation agenda towards universal coverage, however, the complexities that came to characterise healthcare reform and how to address them gave rise to a contestation between an NHI and social health insurance (SHI) scheme as policy options for redress. Central to the policy debates then, as continues to be the case now, is how the NHS is to be funded and organised and what role the private sector should play, if any. These health insurance policy debates predate 1994. Some argued in favour of a tax-funded NHS while others continue to view and promote as the most feasible an insurance based system, despite it falling short of addressing the challenges of the healthcare system. However, little evidence to date suggests that market-driven healthcare reforms have or will play a significant role in ensuring that equity, access and efficiency objectives are achieved for the health system as a whole.

Regardless of its contested nature, the debate has once again resurfaced as an urgent matter of public policy. For instance, at the July 2007 African National Congress (ANC) National Policy Conference, a policy resolution called for a reaffirmation of the implementation of the NHI System. This policy resolution was given further recognition as a policy option to pursue and was endorsed at the ANC National Conference in Polokwane held in December 2007. The challenge is to provide for appropriate systems and processes to make this a reality. This creates the platform to initiate further debate and evaluate progress made towards the realisation of an NHS.

Health policy debates have taken place and evolved within a particular context and have a history that has to be taken into account in contemporary policy discussions. Since 1994, as part of the health system's reform agenda, various committees were set up to investigate proposals on a future health system that would inform policy direction to ensure 'access to health for all'.

Government's initial proposal for an NHI as a policy option drew criticisms, mainly from National Treasury and health professionals, for being too costly

and too rigid. The 1995 Committee of Inquiry into NHI was established to further investigate improved access to healthcare, followed by the follow-up 1997 Committee. The former argued strongly for an NHI system and some of its recommendations were implemented by prioritising reforms to the medical schemes environment as a vehicle towards a future NHS.

Falling short of ensuring a system of 'access to health for all', the 1997 Committee revised the 1995 Committee of Inquiry's recommendations and argued for a phased approach towards ensuring 'access to health for all' by means of SHI, with the NHI seen as a second step.

The results of these policies, together with an increasing divergence of views on how to address health system challenges, further exacerbated inequities – today there are even fewer people on medical schemes and more people now rely on the public health system, or are forced to use the public sector, because they cannot afford the cost of medical aid or private healthcare. Premature exhaustion of benefits results in many people either foregoing private healthcare, or using the public health sector.

There is, therefore, an urgent need to correct these unintended policy consequences. Even though medical schemes are regulated, cost escalations – especially in recent years – have been significant, which points to the inadequacy of legislation in this regard and the industry's inability to contain costs. This is partly the result of the fee-for-service environment in which the private health sector operates.

In 2000, the Cabinet appointed a Committee of Inquiry into a Comprehensive System of Social Security for South Africa, which investigated how to secure and enhance social protection (the social protection concept is broader than the narrow focus on social security) for all South Africans. With regard to health as one of its recommendations the committee advocated an incremental approach towards an NHI system based on multiple funds as opposed to a single-payer model system. However, the recommendations of this committee as related to health have not been consistently implemented and only certain recommendations of this committee were implemented. For example, a risk equalisation fund (REF) is in the final stages of preparation within the medical schemes industry, as is the establishment of the Government Employees Medical Scheme (GEMS) as a state-sponsored scheme.

Legislative reform included the Medical Schemes Act and the National Health Act. These Acts encapsulated many of the articulated policy objectives of the committee. The Medical Schemes Act has been used as the mechanism to regulate the medical schemes in pursuit of the reform agenda. These included the introduction of community-risk rating, open enrolment, and prescribed minimum benefits. More recently the government renewed its commitment to the Comprehensive Social Protection Framework in the 2007 State of the Nation address. At the 2007 ANC Policy Conference, the NHI was once again put forward as the preferred funding mechanism for an NHS.

Health within the framework of a comprehensive system of social security

Confronted with a range of historical challenges, in particular poverty and underdevelopment, the South African government initiated various interventions. Initially the Reconstruction and Development Programme (RDP) provided the framework for these interventions. This was followed by the appointment of a Committee of Inquiry into a Comprehensive System of Social Security for South Africa. This committee proposed that South Africa look beyond social security and adopt the broader framework of social protection. At a conceptual level, a comprehensive system of social security (CSSS) requires some rethinking because South Africans are at a crossroad when it comes to the realisation of the socio-economic rights of all, especially the working poor and those who are outside of the labour market.

The choice of change for South Africa lies between reinforcing a residual, narrow concept of social security that responds only to certain sectors of our population, or of taking decisive policy and programme action to implement comprehensive social protection measures that address both structural unemployment and the multiple dimensions of poverty and deprivation.

In reviewing the 13 years of our democracy, the rationale for a paradigm shift from a social safety net to comprehensive social protection becomes evident. The reports and recommendations of the Committee of Inquiry vis-à-vis the CSSS speak to the appropriateness of such a system. Terms or concepts such as social security, social assistance and social protection – often used

interchangeably – have underlying values and beliefs that inform the choices made by decision-makers.

Historically, social security gained formal recognition in 1944 when the International Labour Conference recognised a basic income for all in need of such protection, and comprehensive medical care as a right. Today, the term social security can cover a range of income support measures, including privately-provided pensions, contributory social insurance systems administered by governments, or general tax-funded government social assistance payments. Social security measures, especially of the private contributory kind, based on agreements between employers and employees, are typical of industrial countries where there is virtually full employment based on social accords negotiated between workers and employers and regulated by governments. These measures cover temporary hardships that individuals experience during their life cycle assuming full employment of the working age population characteristic of wealthy states of industrial Europe.

The Committee of Inquiry argued that it is not possible to adopt such a model of social security in South Africa or in the context of developing economies.

Firstly, individuals cannot contribute to social insurance payments if they are not in paid work. In the context of high and persistent levels of unemployment, chronic poverty and growing informal work, social security or a safety net is not a viable option in its traditional form since it would exclude the majority of unemployed people.

Secondly, government social assistance benefits typically extend to poor unemployed individuals in a residual or safety net fashion. Such benefits essentially seek to ameliorate the difficulties of those who cannot get paid work because of ill health, disability or other factors not related to structural conditions. South Africa, because of structurally based inequalities and chronic poverty, requires a more active and comprehensive social protection system with the potential to contribute to assets redistribution; and it must include measures to address the structural basis of poverty and deprivations in health, education and access to waged work. Unemployment, poverty, macro-economic shocks and financial volatility, the HIV/AIDS crisis and other challenges require more than a social safety net.

All these challenges require a comprehensive system that provides a continuum of care linking public and private provisions efficiently and equitably. In

discussing comprehensive social protection measures, we understand the need to have, as a minimum, standards of well-being that enable all people to live with dignity. Adopting minimum standards and measures requires social consensus on what these constitute and how we as a country are determined to protect the core of all human lives. The progressive realisation of access to social security and other socio-economic rights, as set out in the Constitution, is what distinguishes South Africa as a developmental state.

While the Constitution provides support for extending the social security system, a political mandate also exists for the extension of social security. In 1994 the ANC campaigned under an election manifesto that included welfare rights for all. The RDP policy framework of the ANC, launched that same year, identified a developmental social welfare programme as the attainment of basic social welfare rights for all South Africans as a main goal, irrespective of race, colour, religion, gender and physical disability through the establishment of a democratically-determined, just and effective social delivery system.

The South African government therefore had the firm historical base, the political mandate and the constitutional and normative imperatives to expand social security to provide comprehensive social protection to all. Of real importance is the task of constructing a comprehensive social protection system that is responsive to chronic poverty, to deprivations, education and health.

Discussions on CSSS measures focused on the arrangements that would best respond to South Africa's challenges without increasing poverty levels. This included inputs on a range of options, from general tax funding, dedicated taxes, mandatory payroll contributions and voluntary contributions. Given South Africa's demography, government has to be directly involved in the provision of preventive, promotive and curative health services. The range and scope of tasks and responsibilities is a crucial issue for ongoing discussion.

This concept of comprehensive social protection was adopted by government in 2003, in order to 'provide for the basic needs for all the people living in the country to effectively participate and advance in social and economic life, and in turn to ensure, collectively, at least a minimum acceptable living standard for all citizens' (Committee of Inquiry into a Comprehensive System of Social Security for South Africa 2002). It outlines a package approach 'in the context of the three pillars of social security.' These pillars are:

Pillar 1 *Universal non-contributory system*: Social assistance and the social wage – with respect to healthcare funding this includes tax funding of health services.

Pillar 2 *Mandatory contributory system*: Social insurance – this includes mandatory health insurance in which those who can afford must contribute in a system based on social solidarity.

Pillar 3 *Additional voluntary arrangements:* Voluntary contributions for benefits over and above pillars 1 and 2 include voluntary health insurance (medical schemes).

It was noted that significant progress has been made with respect to social programmes including:

- income security in which government provides income support to more than 12.7 million beneficiaries;
- social insurance with the coverage of the Unemployment Insurance Fund (UIF) expanded to cover domestic and farm workers (more than one million people), and improvements in UIF governance (accumulated reserves of R19 billion);
- basic services and non-financial transfers – the social wage such as free basic services (74% of the population now has access to free basic services); and
- access to assets such as housing (2.35 million houses delivered since 1994) and land.

Health services and healthcare funding formed part of the inquiry and is included as an element within the CSSS framework. With respect to the health component, the Committee of Inquiry recommended that we 'move towards a national health insurance system over time that integrates the public sector and medical schemes environment within the context of a universal contributory system' (2002).

Specific recommendations of the committee included the following:

- the health budget to be ring-fenced to allow for provincial discretion within a nationally-defined policy framework;
- a reconsideration of the tax subsidy for medical-scheme contributions within the context of a strategic health policy rather than tax policy;
- the establishment of an REF within the private insurance sector;

- the medical scheme environment should move ultimately to legislated mandatory membership where feasible;
- attention should be given to cost containment in the private health sector;
- public hospital reforms which should include the following elements:
  - decentralised governance and management
  - CEO as accounting officers
  - differential amenities under controlled conditions without any differentiation of services
  - revenue retention;
- the establishment of a state-sponsored medical scheme; and
- the establishment of a civil service medical scheme.

Section B
Colloquium inputs and discussions on key themes

Overview of the key themes

The colloquium was structured around four key themes with interactive presentations and discussions by various speakers. The colloquium addressed the following key themes, with presentations organised across themes to promote interactive debate:

- Trajectory for a future national health system (NHS): the reform path since 1994
- Critical policy options for health within the context of a comprehensive system of social security
- Local and international evidence of health system models
- Health system reform and stakeholder engagement.

Theme 1: Trajectory for a future national health system: the reform path since 1994

Deliberations focused on current policies, promulgated legislative frameworks, the extent of implementation, and progress achieved towards central policy objectives. A review of formulated and implemented policies provided an opportunity to evaluate to what extent policy objectives have been achieved, reasons for the lack of implementation and outstanding policy objectives.

The inputs and discussions reviewed the reforms since 1994 and assessed the present status of the health system including healthcare funding. Presentations also focused on some of the broader health system issues – strategic framework, funding arrangements (including hybrid models), institutional frameworks, provider arrangements, and so on – that often 'fall between the cracks' in debates on national health insurance (NHI) and social health insurance (SHI). The role of the Government Employee Medical Scheme (GEMS) was explored – with regard to the phased approach of healthcare financing towards mandatory universal access, as an intermediate social health insurance (SHI) mechanism – and challenges that require interventions were interrogated.

While the total spectrum of health reforms was debated, the focus was on healthcare funding.

Theme 2: Critical policy options for health within the context of a comprehensive system of social security

The discussion on healthcare funding involved an overview of the comprehensive system of social security (CSSS). Besides tax funding, the report of the Committee of Inquiry into a Comprehensive System of Social (2002) also highlighted funding by social insurance schemes through government-sponsored arrangements, for example the Road Accident Fund, Compensation for Accidents and Injuries and medical schemes. Social security reforms that are underway are meant to reverse this uncoordinated and fragmented funding of healthcare coverage.

The overview of government's comprehensive social protection framework, based on three pillars, provided a wide-ranging assessment of progress to date within the social development component of the framework. This was followed by a health-specific assessment, a more detailed exploration of health funding generally, and the question of a mandatory contributory funding model. One of the critical challenges of a contributory model is the institutional arrangements required to administer the funds efficiently and effectively. The South African Social Security Agency (SASSA) is the structure responsible for the management and administration of social security grants. While this is a tax-funded system it still provides many lessons for healthcare funding administration.

Theme 3: Local and international evidence of health system models

Presentations centred on experiences with a tax-funded system, for example the United Kingdom's NHS, as well as on countries that have, or are introducing, SHI-type funding models.

These contributions were valuable both from a health system as well as healthcare funding reform perspective. An input on health insurance mechanisms in the context of a wide range of international experiences, including the introduction of NHI in Ghana, was particularly informative. Discussions regarding the choice of method of healthcare financing systems took place within the context of the key functions that a financing mechanism

must perform in relation to the health system to which it applies (Kutzin 2001). The key healthcare financing functions specify:

- revenue collection, which relates to how health services are funded, organised and harmonised with the rest of the healthcare system;
- pooling of funds, which relates to fiscal stability so that the costs of healthcare are shared by all and not borne by individuals at the time they fall ill. Pooling of funds strengthens solidarity within the context of broader risk pooling and equitable benefits, to spread health risks over as broad a population group and period of time as possible; insulating individuals against financial risk exposure at time of illness;
- purchasing of services, which involves the use of pooled funding to buy or provide appropriate and effective health services;
- provision of services, which relates to the organisational delivery arrangements;
- payment systems (method and amount per unit of service provided), which include the allocation of funding to healthcare providers and rationing with impacts on the cost, efficiency and quality of health services provided; and
- healthcare coverage, which relates to the core benefit package to be provided.

Theme 4: Health system reform and stakeholder engagement

Presentations and discussions centred on the affirmation of the constitutional and legal imperative to provide for the healthcare needs of all citizens. The extent to which we have succeeded, or in certain instances not succeeded, to achieve healthcare provision for all was highlighted. A proposal was made for a conceptual framework for a basic healthcare package (BHCP) covering all levels of care. Concerns were also expressed over the unsustainable cost escalation in the private health sector.

However, as one speaker at the colloquium noted, 'both economists and health policy analysts tend to provide detailed prescriptions on what should be done but without clear instructions on how to do it'. This input focussed on the considerations, processes and interventions necessary when designing an implementation plan to change health funding policies and models. Such an implementation plan would require coalitions of support with the necessary leverage – involving both processes needed to change policies and actual implementation of policies.

Healthcare provision

Improving the provision of health services in order to improve health outcomes forms the central purpose of health reform, with the development of an optimal funding model as the secondary objective. Such a funding model is intended to ensure an equitable and cost-efficient health service. Government's legislative and policy context for healthcare provision is outlined below.

Legal context

The National Health Act (Act 61 of 2003) mandates that 'the Minister must, within the limits of available resources...ensure the provision of such essential health services, which must at least include primary healthcare services' to the population of the Republic as may be prescribed after consultation with the National Health Council.

The 1996 policy document of the Department of Health on the *Restructuring of the National Health System for Universal Primary Care* sets out the policy objectives of the NHS as well as the basic principles that would govern the reform process. The goal is to implement a comprehensive restructuring of healthcare in South Africa, aimed at the development of a comprehensive, efficient and equitable NHS. More specifically, the policies aim to achieve:

- substantial, visible and sustainable improvements to the accessibility, efficiency and effectiveness of publicly funded primary healthcare services;
- improvements in the funding, efficiency and governance of the public hospital system; and
- improvements in the equity and efficiency of the private health sector, and in the interaction between the public and private healthcare systems.

Any reform (structure, organisation and functioning) towards an NHS should be guided by the following principles:

- universal access;
- building on and strengthening the existing public sector primary healthcare and hospital system;

- congruency with, and strengthening of, the emerging district-based healthcare system;
- a comprehensive primary healthcare approach (PHC), using population-based planning and delivery mechanisms;
- integration and consistency with other levels of the national health system;
- optimising the public-private mix in healthcare provision, and ensuring the achievement of redistribution of resources between the private and public sectors;
- preserving the choice of individuals to use private providers and to insure themselves;
- emphasising the needs and rights of users of the system, and empowering users and their communities to participate in governance of the healthcare system;
- ensuring the system is outcomes driven, and placing substantial emphasis on quality of patient care, on health outcomes and on the 'caring' aspects of healthcare services; and
- organisation and functioning should be based on the principle of decentralised management, which aims to create the maximum possible management autonomy at health facility level within the framework of national public service guidelines.

Policy context

The policy objectives and basic principles of the NHS are still applicable. Despite the challenges, progress has been made in the following areas towards restructuring the health system in the direction of an NHS:

- Access to primary healthcare services have improved with the construction of a network of primary healthcare centres. Financial barriers to access have been reduced with the introduction of free primary healthcare and care for pregnant women and children six years and younger.
- The comprehensive primary healthcare approach in the public sector has largely replaced the fragmented system which separated preventive/promotive care from curative care.
- Geographic distribution of health professionals has improved with the implementation of community service and the more recent introduction of rural and scarce skills allowances.

- Many elements of the district health system (DHS) have been implemented, such as the demarcation of contiguous districts aligned to the district municipal boundaries, organising services on a district basis and establishing appropriate referral systems.
- The elements of allowing individuals to choose private sector provision and to insure themselves are in operation.

In spite of this progress, there remain challenges to implementation, which prevent the full realisation of an NHS.

Inadequate human resource provisioning: Attempts at strengthening the public sector (primarily through ensuring adequate human resource provisioning) remain a significant challenge. Out-migration of health professionals from the public to the private sector, as well as to other countries, is a critical issue. Out-migration reduces the available resources – with a disproportionate workload being placed on existing personnel. All these factors impact on staff morale, quality and working conditions. Increases in the disease burden, with significant increases in public sector patient load (particularly as a result of the HIV/AIDS epidemic), have made this challenge more evident. A health human resources strategic plan has been developed in an attempt to deal with this central issue. The implementation of this plan should be supported.

Coherent funding arrangements and coordinated governance of the DHS: This area requires attention if management decentralisation, especially with respect to human and financial resources, is to be implemented. Improving this aspect will increase the functionality of the other DHS components that are in place. Moves towards the creation of a single public service that will include local government could have a bearing on this issue.

Public hospital reform: Set out in the initial formulations, this has since been incorporated into policy positions. The previous hospital superintendent systems have been replaced by a CEO approach, with the intention to improve efficiencies within public hospitals. However, the management decentralisation that was intended to accompany this change has not been implemented to the desired extent. This may well be attributed to the lack of managerial and administrative capacity in these hospitals. These constraints to implementation should be reviewed.

Optimisation of the public-private mix and the redistribution of resources: This shift in favour of the public sector is an element of the NHS in which

it appears that the least progress has been made. Public and private sectors are largely completely separate systems with significant inequalities and insufficient cooperation and coordination. The inequitable distribution of resources, in particular human resources, is still prevalent and poses a major challenge to the development of an NHS. One of the major reasons why this strict separation is sustained is the funding model in which voluntary health insurance contributions (medical schemes) fund the private sector almost exclusively. This is therefore the area in which the implementation of an NHS is most closely related to the healthcare funding model. Reform of the funding model is therefore an essential component in the development of the NHS.

Cost escalation: Private healthcare costs have escalated to levels that are becoming unsustainable. This is a critical constraint on the development of an NHS, and containing these costs becomes a vital component of a move towards an NHS.

Experiences in other countries

In evaluating the extent to which we are achieving an NHS it is useful to study experiences in other countries, such as the UK. The UK established its NHS in 1948, and there are useful lessons to be learnt from this example.

The UK's NHS is governed by principles of:

- being universal and comprehensive – covering everything and everyone;
- equity; and
- being free at point of use.

While there is a private sector, it is not as large as the South African private sector as a proportion of total expenditure. The major component of the UK's NHS is therefore a tax-funded system. Problems within the system include: over-centralisation with disempowered patients; lack of national standards; and under-investment in the system. In addition, resource constraints also lead to choices and prioritisation so that the concept of comprehensive and universal care is illusive. Similarly, achieving equity is particularly challenging and there is a sense that an NHS solves the problem of eligibility but not necessarily that of equity.

Healthcare funding

Revenue sources

Tax funding

Public health services in South Africa are funded largely from general taxes within the fiscal federal system through which tax revenue is allocated. Provinces receive an equitable share for allocation to various provincial departments, including health. This gives provincial governments significant discretion in the funds allocated to the provincial health departments. In addition to the equitable share funding, health services are also funded through conditional grants which largely limit provincial discretion.

Provincial discretion in health allocations leads to wide discrepancies in the percentage of provincial budgets allocated to provincial health departments as provinces apply their own allocative priorities. This situation may lead to inter-provincial inequity in health services. It may, however, be argued that this does not necessarily lead to inequitable health outcomes because other social determinants of health are being funded.

In order to address this inequity, if the present fiscal federal system is retained, a set of national norms and standards for provinces should be implemented. In addition, other conditional grants or ring-fenced allocations could also improve equity. Historical patterns of public health funding from general taxes are interpreted by different contributors to indicate either no significant increase, or a significant increase during the preceding few years. It is important for these different interpretations of the data to be reconciled for any meaningful discussion on public healthcare funding from taxes to take place. Apart from the trend analysis on public sector health funding, an assessment of whether healthcare funding is adequate may also be approached from different perspectives.

The Abuja Declaration proposed that governments within the African Union spend 15% of their budgets on health services. It would be necessary to

interpret these figures in order to determine the extent to which South Africa is achieving the objectives of the Abuja Declaration. Indirect tax funding of private medical schemes occurs via the tax subsidy on medical scheme contributions. This amounts to approximately R10 billion per annum. This has been capped in recent reforms. It is intended to incentivise cover in a voluntary contribution system. Nevertheless, higher income groups still benefit more from the tax subsidy than lower income groups. In addition, substantial tax resources are used to purchase medical-scheme cover for civil servants.

Reform with respect to this subsidy is necessary. The per capita amount of the subsidy is higher than the per capita amount spent in the public sector. Given that medical scheme funds are primarily spent in the private health sector it appears to be strengthening the private sector at the expense of the public sector.

Reform proposals made by the Committee of Inquiry into a Comprehensive System of Social Security for South Africa (2002) on this subsidy centred chiefly on the removal of the subsidy on medical scheme contributions in favour of a direct subsidy which is linked to the cover available in the public sector. The Department of Health appears to favour this approach, with the subsidy being paid into a risk equalisation fund (REF) to ensure adherence to the principle of social solidarity. An alternative view is that the subsidy should be done away with entirely. This may, however, disadvantage low-income earners who are contributing to medical schemes who will then not receive tax-funded contributions to their healthcare on par with those who use the public sector.

The UK's NHS is an example of a system that is tax funded and provides good insights on the advantages and disadvantages of such a system.

Voluntary insurance funding

Healthcare insurance funding in South Africa at present falls into the category of voluntary insurance within Pillar 3 of the comprehensive social protection framework. These funds are administered through medical schemes. Medical scheme contributions are made by both employers and employees.

Currently there are 125 medical schemes in South Africa. This number may not allow for large risk pools, which are necessary for the insurance model to function optimally. The majority are open schemes while a minority are restricted to particular employee groups. A significant increase in open schemes has occurred since 1996. Medical scheme membership has remained fairly constant in the last decade at 7 million. This represents 14.5% of the South African population in 2005, compared to 17.5% in 1996. Administration costs are an important cost driver within the industry, increasing significantly above the consumer price index (CPI). Over the five-year period from 1999 to 2004 administration costs increased by 125%, compared to CPI at 27%. These costs are as high as 12.5% of gross consumer income. Increases in private sector provision, administration and third-party costs have resulted in significant above-CPI increases in medical scheme contributions.

A revised regulatory framework for medical schemes was implemented through the 1998 Medical Schemes Act. This included:

- a single act to govern all funds doing the business of a medical scheme;
- community rating;
- prescribed minimum benefits;
- open enrolment for open schemes; and
- an expanded regulatory authority, the Council for Medical Schemes, reporting to the Minister of Health.

These reforms were meant to facilitate the progression towards an SHI system. Various committees have recommended the establishment of a state-sponsored medical scheme (SSMS) as part of the progressive realisation of a mandatory insurance system. This could be preceded by a public service medical scheme. Many advantages have been identified, including:

- availability to low-income earners;
- strengthening of the public sector through provision controls; and
- low administration costs

The conceptual framework of an SSMS is similar to that of an SHI, except that it would operate within the medical-scheme dispensation, whereas an SHI is usually envisaged as being an insurance model functioning within a specific regulatory environment.

The recommendation of the Committee investigating a CSSS on a civil service medical scheme was accepted by the government and the Government

Employees Medical Scheme (GEMS) was introduced. This scheme is restricted to public servants and has different packages that ensure affordability for all public servants. While it functions as a regular medical scheme, its least expensive option allows only for public service hospital care. Given that it is administered by the state, it may be considered an SSMS restricted to public service employees. While there are certain factors that still have to be addressed, it does allow for the possibility of extending cover to all other employee groups. The low-cost option, in particular, could ensure affordability for all the formally employed.

Another significant reform is the imminent introduction of REF. Government approved the introduction of an REF within the medical scheme sector. This is intended to equalise the risk between different medical schemes given their different risk profiles. The risk parameters used are age distribution, gender and chronic diseases of the members of the scheme. It is envisaged that schemes with a good risk profile will contribute to those with a high risk profile.

Mandatory insurance funding

Mandatory health insurance falls within Pillar 2 of the CSSS. It refers to health insurance in which all the formally employed above a certain income level are obligated to contribute. In the case of SHI, these contributors are also the only beneficiaries of the scheme, whereas with an NHI both contributors and non-contributors are beneficiaries. An NHI system therefore ensures universal coverage.

As stated earlier, the primary responsibility is to develop a health system that provides all citizens with adequate healthcare at an affordable cost (on equal terms and conditions). Payment is according to ability to pay and benefits according to need, which implies both income and risk cross-subsidisation in the overall health system. Any funding model must aim at achieving these objectives. In developing a model for mandatory insurance, the contribution structure (single rate or changing percentage as income changes, level of maximum contribution ceiling) must be progressive. It is meant to reflect social solidarity through both income and risk cross-subsidisation. The former is achieved through progressive insurance contributions and the latter through community risk rating and an REF.

Introducing mandatory insurance depends on finding a feasible option that is affordable and acceptable to employers and employees, and progress with reforming both public and private provisioning.

The advantages of mandatory insurance include:

- benefits at lower cost for a larger group through higher volumes – this reflects the advantages of large risk pools;
- bulk purchasing in which the power of the purchaser is increased through volumes; and
- lower transaction costs – the transaction costs of SASSA are 6% compared to private schemes at 12%.

Concerns raised with respect to deliberations on mandatory insurance were:

- affordability, depending on the percentage of the wage made up of contributions, which depends on the cost of the services as well as administration costs. This is particularly important if the private sector is a significant provider.
- acceptability to employers and employees. This is particularly important in the case of a pure NHI where, in the presence of high unemployment and a significant informal sector, the number of beneficiaries is significantly higher than the number of contributors. This situation will improve as the employment levels increase, the per capita income rises and there is a significant shift from the second to the first economy.
- effects on the cost of labour and the macro-economy.

A mandatory contribution could be considered an earmarked health tax, which may be viewed as increasing the tax burden on both employers and employees. All the advantages associated with larger volumes, as well as an improved service provision, must therefore accompany such a model.

International experience with mandatory insurance is instructive. During discussion, views were expressed about Latin American countries where SHI-type arrangements have been introduced with varying degrees of success. Countries that have introduced SHIs include Argentina, Mexico and Columbia. About 50% of the labour force of these countries is in sectors that would contribute to an SHI. Non-contributors are therefore a significant proportion of the labour force. High unemployment and large informal economies are also features of these countries. Contributions are 12% of wages and any reduction in contributions requires significant government funding,

for example in the case of Mexico where the Popular Health Insurance contribution is 5%. In spite of this, the package of services is limited. Given the Latin American experience, the question remains whether SHI – in the presence of a high non-contributory sector – may be an intermediate step towards NHI.

Valuable lessons may also be learnt from the introduction of mandatory insurance in Ghana. In their case the goal of universal coverage, akin to an NHI, was pursued from the outset. District-wide medical schemes were established covering the formal and informal sectors funded by:

- payroll deductions for formal sector workers via social security;
- direct contributions from others (those working in the informal sector);
- a levy of 2.5% of VAT;
- tax and donor funding to subsidise the pool; and
- risk equalisation applied between the district schemes.

Pooling of funds

Pooling of funds refers to the accumulation of prepaid revenues on behalf of a population. Those systems in which the degree of risk pooling is greatest achieve more. Highly individualised payment systems, such as out-of-pocket payments and savings accounts, allow no or little risk pooling. Multiple insurers, such as the large number of medical schemes in South Africa, give rise to small risk pools. The REF within the medical scheme environment is an attempt to achieve the advantages of a larger risk pool. The ideal would be to have a single risk pool underpinned by social solidarity principles. Factors that influence progress towards a single large risk pool include:

- the level of income and economic growth;
- the size of the formal sector;
- the level of urbanisation;
- administrative capacity; and
- the extent of social solidarity and acceptability of cross-subsidies.

If both mandatory insurance contributions and tax funds are pooled, institutional arrangements required to administer these funds should be considered. Proposals in this regard include the establishment of a resource allocation authority or a central equalisation fund. Currently, social security benefit funds are pooled and administered by the SASSA, a focused, specialist

institution responsible for the management, administration and payment of social security benefits to the value of R68 billion (or >3.4% of GDP) to 12 million beneficiaries. It functions separately from the government but is accountable to the Minister of Social Development. In considering a similar arrangement for health funding, the agency might be a valuable source of information in dealing with large benefit pools. Important elements of SASSA that could be of interest in the establishment of a structure for health fund administration are:

- funding sources – in the case of SASSA this is exclusively from government taxes;
- governance structure, including accountability mechanisms;
- management structure;
- budget size (R68 billion) and beneficiary numbers (12 million);
- information systems; and
- administration costs as a percentage of budgets (presently 6%).

While the multiple funding sources (tax and mandatory insurance) of a health structure, as well as the differences between grant payments and health services purchasing, would need to be considered, SASSA is an important structure to evaluate. SASSA is also important to healthcare funding because of the placing of healthcare within the context of a CSSS of which SASSA, as a disbursement mechanism, is a component. As a Pillar 2 contributing social security environment is introduced, SASSA may begin to deal with non-tax funding sources. Within social development these will include death benefits, retirement benefits and unemployment insurance. The latter benefits are currently administered through the Unemployment Insurance Fund. Mandatory health insurance would be considered an extension of this contributory system to healthcare as a component of a CSSS within Pillar 2.

Purchasing of healthcare

This involves the transfer of pooled funds to providers on behalf of the population covered. In the case of NHI this cover will be universal.

What is being purchased?

Agreement must be reached on a BHCP which covers all levels of care. Each level of care, from primary to quaternary, should be included in a BHCP. Adequate effective gate-keeping and referral systems between the different levels of care are important.

After the introduction of the 1998 Medical Schemes Act, Government embarked on the development of a minimum benefit package which was captured in regulations as 'prescribed minimum benefits' which binds the medical schemes.

The National Health Act (Act 61 of 2003) mandates that 'the Minister must, within the limits of available resources ensure the provision of such essential health services, which must at least include primary health services that the state can provide'. This need for a basic package of care is also endorsed by the Health Charter.

A core component of a future basic package of service is the longstanding essential drugs list (EDL) programme. This is aimed at defining those drugs that are considered an essential component of the basic benefit package.

How do we pay?

Payment mechanism impacts on whether a system is accessible, equitable, as well as on healthcare costs. Payment mechanisms may be classified into:

- pre-payment; or
- point-of-service payment.

General consensus was reached that a pre-payment system is the best mechanism to ensure greater equity and access. Any of the funding sources,

from general tax (through budgets) to various forms of insurance, can utilise pre-payment mechanisms.

A more challenging area involves the use of:
- capitation payment; or
- fee-for-service.

This requires extensive consultation with providers. While there are arguments for and against both systems it does seem that the risk of over-servicing and cost escalation requires a review of the fee-for-service option. In the case of a mandatory insurance system, especially with respect to a basic benefit package, the capitation system appears to be the most viable.

Feasibility and acceptability also relate to whether provision is public or private, with public provisioning allowing for capitation and private provisioning favouring fee-for-service.

Purchasing power

Power imbalance between the purchaser and the provider is a critical factor in the pricing of services. Purchasers such as the medical schemes can ensure that costs are contained by achieving high volumes through consolidation which will increase their leverage in price negotiations. This becomes progressively more challenging with the organisation of providers into a few entities which stymies competition.

Section C
Discussion and recommendations

Discussion and recommendations

Having considered the range of issues involved in health system and funding reforms, it is necessary to discuss all these elements in order to make inputs into the policy formulation process. We also need to propose a systematic approach to the implementation of the various policy options.

An essential first step towards health funding reform appears to be the need to make progress towards an NHS, based on the principles set out earlier with respect to the public health sector. This would necessitate the finalisation of any elements of the DHS which are still outstanding, in particular the governance arrangements.

Public hospital reform should be finalised, including the elements of physical infrastructure, decentralisation of governance and management, revenue retention and differential amenities. In order to strengthen and reform the public health sector, attention must focus on human resources as well as tax funding of the health system. The Department of Health has produced a human resources strategy which is an important point of departure (NDoH 2006). Stakeholders should engage with, and contribute to, this strategy in a dynamic way, and its implementation must be prioritised. This could then achieve the goal of increasing the number of health professionals as well as the management and administrative capacity of the public health system.

Tax funding of healthcare should receive attention. While the different views on the expenditure trends within the public health sector should be reconciled, funding still appears to be inadequate. The overall percentage of GDP spent on healthcare is distorted by the excessively high proportion spent in the private health sector. Currently the public health sector receives 11% of government funds, while the Abuja Declaration has proposed a level of 15% for African Union members. If this is due to health expenditure being considered part of overall social security expenditure, this should be clarified. Whatever the underlying reasons for these allocations, public sector strengthening requires increased tax funding as part of Pillar 1 of the social protection framework. Any move towards Pillar 2 would be difficult if Pillar 1 is not adequately resourced.

As pointed out earlier, significant inequity exists between the private and public health sectors. Of the 8.3% of GDP spent on health services, 4.9% is spent in the private sector and 3.4% in the public sector. Containing costs in the private sector and redistributing human resources, in particular, from the private to the public sector is essential for the establishment of the NHS.

Health funding reform is also dependent on reducing costs because, irrespective of the funding model, the cost of healthcare could be unaffordable. Reforming the tax subsidy system in order to reduce, or eliminate, the indirect funding of the private healthcare industry is also a possible mechanism to shift resources from the private to the public sector. With respect to private healthcare funding, the 1998 Medical Schemes Act has led to some control being exercised through the Council for Medical Schemes. Regulating the medical schemes, however, appears to be an insufficient tool to contain costs. Other areas of medical scheme reform appear to have been more successful.

In terms of the government's comprehensive social protection framework, Pillar 2 contributory systems will be introduced. In the case of health this would include mandatory insurance. But how this should be introduced is a matter for debate. Emerging consensus seems to favour NHI as the ultimate funding model. This presents challenges in the presence of a significant non-contributing population who will also be entitled to benefits. This has led to a view that SHI could be an interim step towards the NHI. Experience, particularly in Latin America, has cautioned against this approach.

In order to reach consensus on the direct implementation of an NHI versus an SHI as an intermediate step, it may be useful to regard an SHI mechanism (mandatory contributions by all the formally employed above a certain salary level) as an element of an NHI mechanism (universal access to the funded benefits). This approach will allow us to discuss health-funding reform using the Kutzin approach. Revenue will be derived from the mandatory contributions as well as from government tax contributions on behalf of the non-contributing population. This will overcome resistance from contributors to subsidise a large non-contributing pool. It also recognises the fact that health services will be dependent on significant tax funding for the foreseeable future. Both sources of revenue can be collected by the South African Revenue Service (SARS) through the normal tax administration system which obviates the need to set up a new revenue collection system.

Once collected, the funds could be pooled within an institutional arrangement which may be similar to SASSA or any other entity such as a resource allocation agency or a central equalisation fund. Pooled funds will meet the requirements for social solidarity. If SASSA itself is considered, it will have the advantage of being in operation already, and with the introduction of the Pillar 2 contributory system for the other elements of the social protection framework, it will be administering both tax and payroll contributions.

Another option is to use GEMS for both revenue collection and pooling. This would entail GEMS's mandate being extended beyond the public service and contributions would become mandatory. A disadvantage could be the fact that it is governed by the Medical Schemes Act, which may not provide an optimal regulatory environment for a Pillar 2 mandatory contributory system.

Purchasing mechanisms would favour a capitation system with fee-for-service being reserved for defined services. Reaching agreement with service providers on this issue presents a major challenge.

Service provision will be by both the private and public sectors – the public sector having been strengthened as described earlier. A BHCP will be defined for all levels of care. Such a package will have to be costed in order to determine affordability, the contribution levels and the capitation fees. Work has already commenced on costing of service packages which will provide a point of departure.

Pillar 3 voluntary insurance schemes will still operate with the public sector competing to provide services to medical scheme members. Such competition could contribute towards cost containment in the private sector.

Key issues and proposals

The key issues that emerged during deliberations, and that form part of the proposals to be taken forward in future discussions, include the following:

- Advocacy for an NHS as envisaged by the ANC's national health plan (see ANC 1994), namely a centrally-funded, basic package of care, free at point of use.
- In pursuit of the NHS, the following steps need to be taken:
  - strengthening the public sector through increased human resource capacity by implementing the human resources strategy; improved

governance of the DHS and public hospitals; and increased funding of public health;
- equitable distribution of healthcare resources between the users of the public and private sectors;
- improving the public/private interface so as to explore various synergies such as the sharing of resources to improve efficiencies;
- curbing excessive costs in the private sector; and
- reforming the tax subsidy of medical scheme contributions to reduce the indirect funding of the private sector.

The following suggestions were offered in relation to healthcare funding:
- Funding of the NHS could take place through tax funding and mandatory contributions, revenue collection by existing institutions such as SARS, and pooled funds administered by SASSA, or a resource allocation agency, or a central equalisation fund.
- GEMS could be an alternative system for revenue collection, pooling of funds and administration, in which case the BHCP could be offered by its low-cost Sapphire option.
- Services could be purchased from both the public and private sectors at affordable rates.
- A capitation payment system could be used with fee-for-service reserved for specified services.
- Affordability, percentage contribution and capitation fees could be determined by costing the BHCP.

Bringing about a change in financing policy is not only a matter of sound technical analysis or 'political will'; it also requires attention to the process of change. Strengthening future policy change is dependent on the following interventions:
- generating a strong information base for policy change;
- opening the debate on financing policy goals to a range of stakeholders;
- recognising the need to actively manage role-players and processes;
- strengthening entities responsible for bringing about change; and
- actively planning for and managing implementation.

In conclusion, policy effectiveness depends on the manner in which they are discussed, approved and implemented. In order to ensure that these key issues are communicated to government as the primary driver of these processes, it is proposed that a team be constituted, and tasked with the responsibility of engaging government.

List of participants

Delegate	Organisation	Position
N Berger	Aids Law Project	Head of Policy Research
Dr M Blecher	National Treasury	Director: Social Services Sector
S Boas	Unemployment Insurance Fund	Commissioner
Dr D Bomela	South African Medical Association	Head of Corporate Affairs
S Bosman	Pharmaceutical Society of South Africa	Professional Officer
Ms C Botha	HSRC	Researcher Manager (Policy Analysis Unit)
H Dayal	HSRC	Trainee Researcher (Policy Analysis Unit)
Prof. L Gilson	Centre for Health Policy	Professor
Dr M Gantsho	South African Medical Association	Head of Private Practice
K Govender	Department of Public Service and Administration	Deputy Director General: Management of Compensation
Dr R Green-Thompson	National Department of Health	Special Advisor to Minister of Health
Dr M Hendricks	N/A	Health Consultant
Dr C Hongoro	HSRC	Research Director (Policy Analysis Unit)
Dr Z Humphrey	Board of Healthcare Funders	Chief Executive
Dr K Letlape	South African Medical Association	President
Dr P Lloyd-Sherlock	University of East Anglia, UK	Professor

Dr N Mabaso	N/A	Private practioner
V Madonsela	Department of Social Development	Director-General
Dr J Maelane	South African Medical Dental Association	Chairman
Dr S Maile	HSRC	Research Director (Policy Analysis Unit)
F Makiwane	South African Social Security Agency	Chief Executive Officer
Dr T Masilela	HSRC	Executive Director (Policy Analysis Unit)
Prof. D McIntyre	University of Cape Town	Professor
Dr C Mini	Thebe Healthcare Administrators	Corporate Affairs Executive
M Mizilikazi	Department of Local and Provincial Government	Acting Executive Manager: Intergovernmental Fiscal Relations
A Moloi	Treatment Action Campaign	District Coordinator: Gauteng
Dr S Moodley	Department of Science and Technology	Manager: Technology and Social Development
G Mthembu	Treatment Action Campaign	District Coordinator: Ekurhuleni
E Paulus	Black Sash	Consultant
Dr O Picazo	World Bank	Senior Economist
Dr Y Pillay	National Department of Health	Chief Director: Strategic Planning
Dr M Powell	University of Birmingham, UK	Professor
B Raftesath	Pharmaceutical Society of South Africa	Deputy President
Dr F Randera	Chamber of Mines	Health Advisor

M Sadan	Office of the President	Policy Analyst (Social Sector)
M Schneider	HSRC	Research Director (Children, Youth, Families and Social Development)
Dr M Sefularo	Parliament	Member of Parliament
Prof. G Setswe	HSRC	Research Director (Social Aspects of HIV and AIDS)
Dr O Shisana	HSRC	Chief Executive Officer
Dr L Sizane	South African Dental Association	National Councillor
Prof. V Taylor	University of Cape Town	Chair: Committee of Inquiry into a Comprehensive System of Social Security
Dr L Tsiu	South African Dental Association	President
A van den Heever	Council for Medical Schemes	Advisor Social Security Reform
I van den Linde	HSRC	Deputy Director (Corporate Communications)
H Wadee	Board of Healthcare Funders	Head: Health System and Policy

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