

Universal Coverage and Equitable Financing

The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.

This policy brief returns to the objective of universal coverage and issues related to having a National Health Service (NHS) alongside a mandatory health insurance system. The definition of universal coverage used by the World Health Organization (WHO) is used to consider the South African health system and priorities are suggested on a path to improving universal coverage. The International Labour Organization (ILO) has recommended that multiple financing mechanisms be used in improving universal coverage and a suggestion is made for a way forward that uses equitable subsidies to link the subsystems of the health system in South Africa.

1. The Meaning of Universal Coverage

Universal coverage is not, as sometimes simplistically presented, only that everyone is covered. The definition requires a reference to who is covered, for what package of healthcare and to what degree. For example, if there are high co-payments then lower income families may technically be covered but in practice may be unable to afford to access care. The WHO Annual Report of 2010¹ deals with the path to achieving universal coverage and presents a particularly useful graphic for conceptualising universal coverage, as shown below. The same model of universal coverage has been used by McIntyre² and by Engelbrecht & Crisp³ in the South African Health Review 2010.

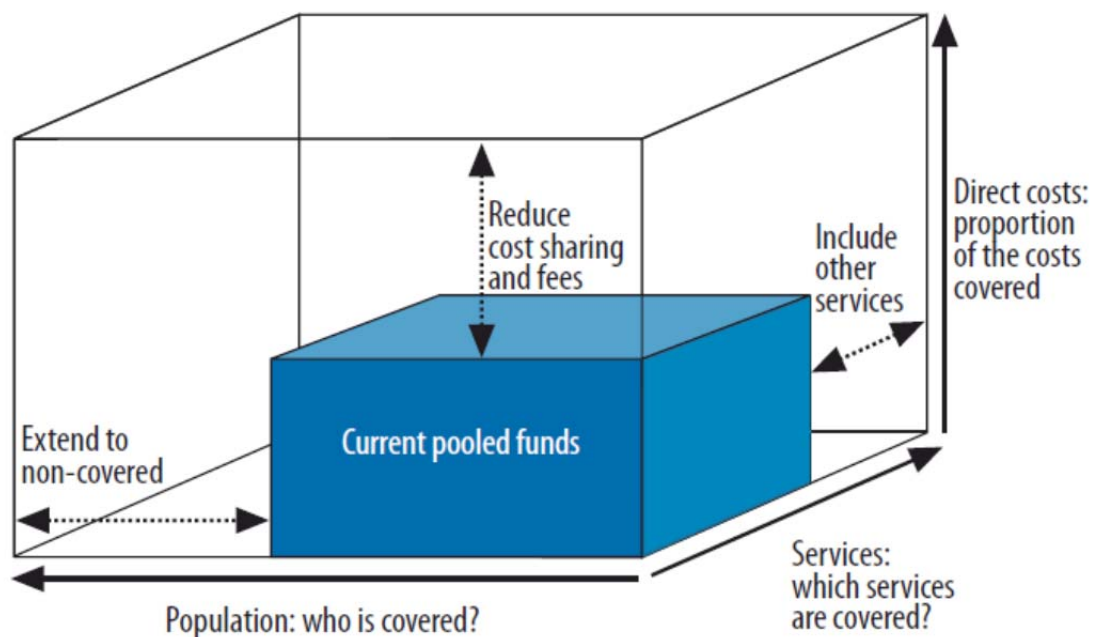


Figure 1: The Three Dimensions of Universal Coverage (Source: WHO¹)

The WHO argues that: “Even where funding is largely prepaid and pooled, there will need to be tradeoffs between the proportions of the population to be covered, the range of services to be made available and the proportion of the total costs to be met. The box here labelled “current pooled funds” depicts the current situation in a hypothetical country, where about half the population is covered for about half of the possible services, but where less than half the cost of these services is met from pooled funds. To get closer to universal coverage, the country would need to extend coverage to more people, offer more services, and/or pay a greater part of the cost.”

The WHO finds that: “In countries with longstanding social health protection mechanisms such as those in Europe, or Japan, the current pooled funds box fills most of the space. But none of the high-income countries that are commonly said to have achieved universal coverage actually covers 100% of the population for 100% of the services available and for 100% of the cost – and with no waiting lists. Each country fills the box in its own way, trading off the proportion of services and the proportion of the costs to be met from pooled funds. Nevertheless, the entire population in all these countries has the right to use a set of services (prevention, promotion, treatment and rehabilitation).”

“The fundamentals are the same even if the specifics differ, shaped by the interplay of expectations between the population and the health providers, the political environment and the availability of funds. Countries will take differing paths towards universal coverage, depending on where and how they start, and they will make different choices as they proceed along the three axes outlined [above]”.

In South Africa, it has been shown⁴⁻⁷ that to provide a fully comprehensive package of care with no co-payments at the level of delivery of existing medical schemes for the entire population would be unaffordable^a. The necessary trade-offs are not technical but political. At best, the technical experts can provide the tools to enable policy-makers to investigate the costs of these trade-offs. Medical practitioners and public health experts can give their recommendations of what the priorities need to be, but ultimately the decisions will be taken by politicians, constrained by the resources available.

2. The Current Status of Universal Coverage in South Africa

Much of the debate about NHI to date has focussed on the breadth or population dimension. While popular perception is sometimes that those without medical schemes “have no cover”, this is not the case. As discussed in Policy Brief 7⁸, it seems though that there is confusion between universal coverage for healthcare and universal coverage for health insurance. It was estimated that only some 16.4% of South Africans had health insurance cover in 2008⁹. However everyone in the country has access to healthcare, either in the public sector or through medical schemes, bargaining council funds or other employer-based arrangements.

In Policy Brief 7 the evidence gathered by Prof Servaas van der Berg on coverage relative to income was shown. His graphs⁸, using the General Household Surveys from 2002 to 2007, show that across all income groups a little over 80% of the population who needed care were able to access care. A further 9-14% decided they do not need to see a healthcare practitioner. Physical constraints (i.e. the distance that needs to be travelled), affected 5% of the lowest income group, reducing as income increased. Financial constraints affected 6% of the lowest income group and this does not vary as much by income as might be expected.

Looking at the averages across the whole population, 82.3% of the population managed to consult a health worker and 10.8% decided it was not necessary to do so. We need to be concerned about the balance, the 6.9% who needed healthcare and could not obtain it: 4.0% said it was too expensive; 1.3% said it was too far and 1.4% had other reasons.

^a There are no public documents on the results of the Actuarial Society of South Africa model of NHI but illustrations have shown results of the same magnitude to those in the references quoted.

The diagram below is a first attempt to draw the three dimensions of Universal Coverage for all the elements of healthcare in South Africa. This is very much a first attempt and it is hoped others will refine the diagram as part of the on-going debate. The population axis has a small gap on the extreme left to represent the 6.9% of the population who were unable to access care when needed.

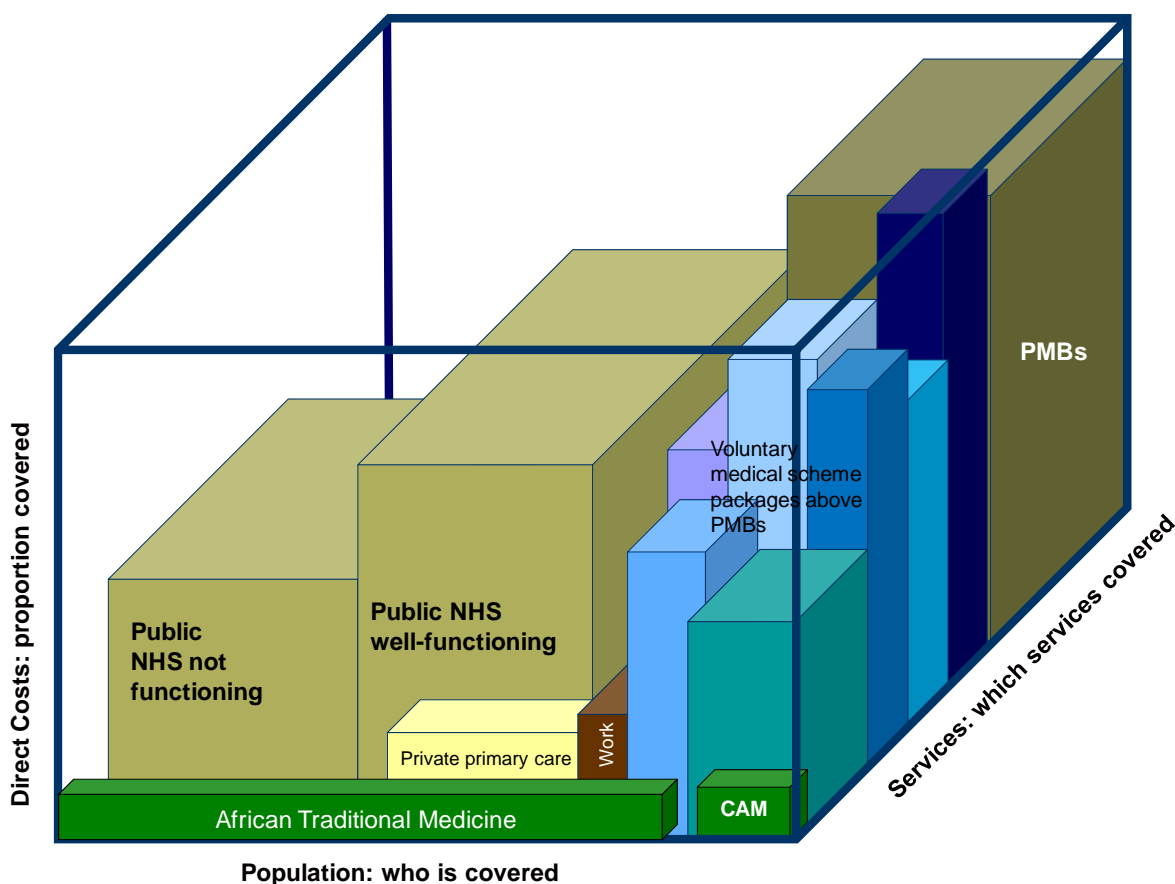


Figure 2: The Current Status of Universal Coverage in South Africa

Prof van der Berg argues that dissatisfaction with the current national health system is dissatisfaction with the quality of the care provided in the public sector⁸. In an attempt to represent the problems in delivery in the current public National Health Service (NHS), two blocks have been drawn. One signifies services and costs in those parts of the NHS that are well-functioning and the other where the NHS is not functioning as it should. In some ways, the analysis is missing a fourth axis which would reflect quality. Here the difference in quality has been represented as providing fewer services and not covering the full costs to the user.

The Prescribed Minimum Benefits applicable to medical schemes are shown as covering about the half the services needed, but at almost full cost. There are some procedures and interventions that are not funded, including using other than the Designated Service Provider (DSPs). Generally PMBs have to be paid in full with no-copayments or limits and thus are shown at a higher level on the direct cost axis. In front of the PMBs are a plethora of voluntary packages that people in medical schemes may take out. There should be as many different groups of bars as there are options in medical schemes: 332 separate packages of benefits in January 2010¹⁰.

Four other elements have been drawn to remind the reader of elements of the system to be included, but their representation on the three axes is not to scale. All four are difficult to draw as they are not paid for by the public health system or medical schemes and thus represent out-of-pocket spend.

- The small “Work” element is to represent bargaining council and workplace-based health services which were discussed in more depth in Policy Brief 15¹¹. This includes healthcare services for those in the workplace with HIV/AIDS.
- McIntyre¹² has long drawn attention to the estimated 21% of the population who use public hospitals but pay for private primary care themselves. Technically this element should show no direct costs being paid by the health system but it then becomes impossible to represent.
- African Traditional Medicine (ATM) is reported to be used by 72% of the Black African population or some 26.6 million consumers¹³. There were estimated to be 190,000 ATM practitioners¹⁴, compared to roughly 27,500 western-trained doctors¹⁵. Trade in ATM medicines contributes some R2.9bn to the economy¹³ which was equivalent to 5.6% of the national health budget, or equal to the whole Mpumalanga health budget, or equal to the KZN Provincial Hospital budget in the same year¹⁶.
- Complementary and Alternative Medicine (CAM) is growing strongly in some population groups, with the total spent on over-the counter CAM medicines in 2007 being some R4bn, equivalent to 43% of medical schemes' spend on medicines out-of-hospital that year¹⁶.

3. A Potential Path to Improving Universal Coverage

The diagram below suggests seven priorities on the path to improving universal coverage and making it more equitable.

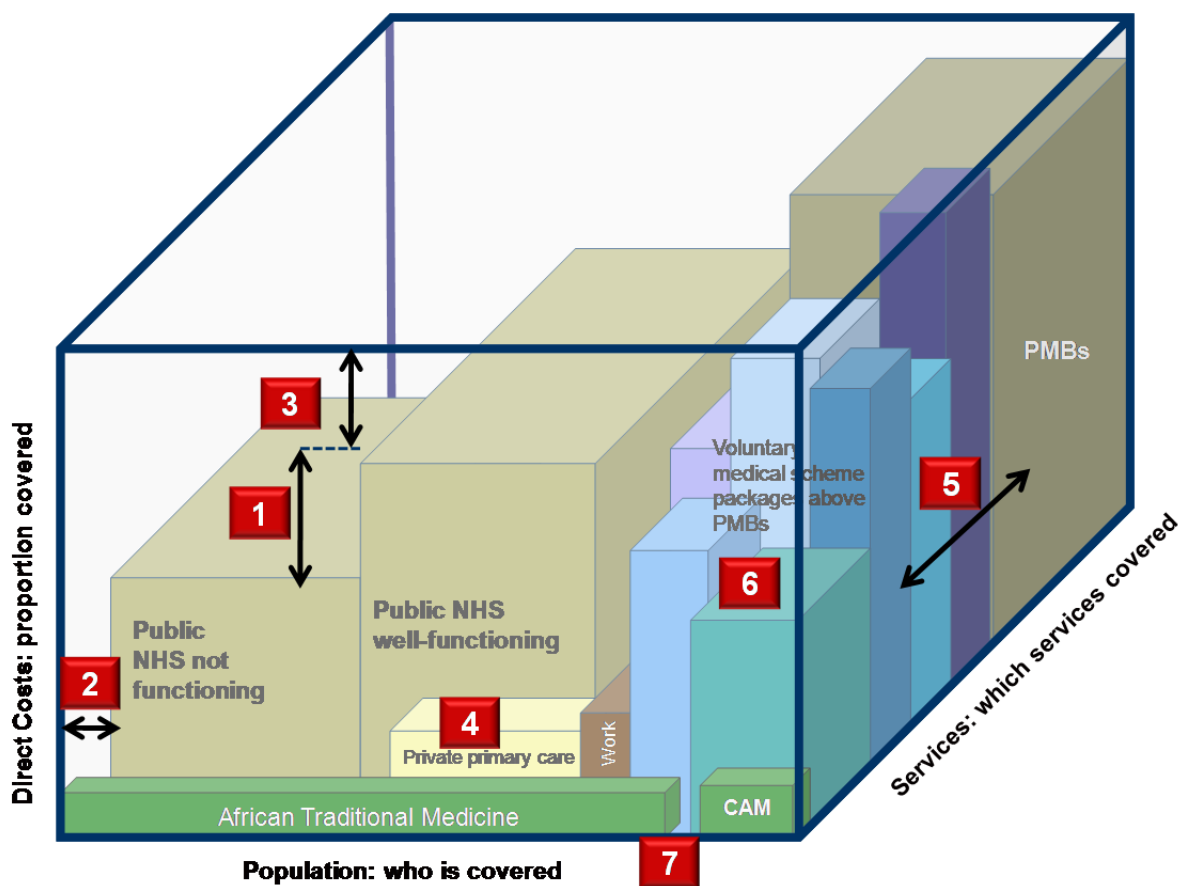


Figure 3: A Potential Path to Improving Universal Coverage in South Africa

In the opinion of the author of this policy brief, the following priorities will provide a practical path to improving universal coverage:

- 1) **Reforms in NHS delivery:** improve the functioning of those parts of the NHS that are not operating at the same standard as the best provinces in the country. This priority has been recognised by the Minister of Health and forms part of the Ten Point Plan agreed with cabinet.¹⁷ In section 4 below the reforms needed are discussed in more detail. This will effectively lift the height of the non-performing block and increase its depth to the same dimensions as the well-performing block.
- 2) **Close the 7% access gap:** close the gap on coverage of the population for the 6.9% of the population who needed cover but could not access it. The reforms described for the NHS should also deal with this gap but the element is specifically highlighted as the issues may be different in different sub-groups of those not covered. It also emphasises that to achieve full coverage of the population is not a big “stretch” for the health system.
- 3) **NHS subsidy policy:** the majority of those who could not access care, 4.0% of the total population, said it was too expensive. This could relate to transport costs but an element that has had little research is the policy on NHS subsidies and their impact on people. See section 5 for more information.
- 4) **Contract with private primary care providers:** Prof van der Berg showed⁸ that most low income people see a nurse as their healthcare provider while high income groups access GPs and specialists. This contributes to the perception of inferior care or lower quality care in the public sector. While medical schemes have been reluctant to force the use of integrated primary care practices except for lower income groups, the State could pioneer the use of integrated nurse / GP / allied health practices by contracting with them as part of the NHS in some areas.
- 5) **Revise the PMB package:** the Taylor Committee argued strongly in 2002¹⁸ that “Government has to move toward defining what it regards as basic essential services which everyone must be covered for. Although these may be defined differently between the public and private sectors, there must be convergence on the approaches adopted in the two environments. Ultimately both the public and private sectors need to provide a minimum core set of services.” While some progress was made in the initial phases of the PMB Review process^{19,20} by the Department of Health and the Council for Medical Schemes, action needs to be taken to advance this issue.
- 6) **Reform of packages above PMBs:** the proliferation of option packages is not in the interests of consumers or healthcare providers²¹. Suggestions for how to simplify the offerings and improve competition were made by the International Review Panel in 2004²². While some stakeholder discussion was held in 2006²³, there have been no major changes in options structures as yet.
- 7) **Integrate ATM and CAM:** African Traditional Medicine and Complementary Medicine are seldom covered by any part of the health system. A few medical schemes provide some CAM cover and some, notably GEMS, provide cover for ATM. Integration into the public NHS is relatively poor. This means that the growing expenditure on these items needs to be funded out-of-pocket by the population. The ANC Health Plan of 1994²⁴ stated that “people have the right of access to traditional practitioners as part of their cultural heritage and belief system”. Commitments made to the African Union to include ATM¹⁴ have been ignored in plans for NHI²⁵. The WHO Beijing Declaration²⁶ calls on governments that have not yet integrated traditional medicine into their national health systems to take action.

4. Reforms Needed in the National Health System

An authoritative view on the reforms needed in the public NHS was provided in the South African Health Review 2010 by two people with extensive public sector experience, Dr Beth Engelbrecht^b and Dr Nicholas Crisp^c.

Engelbrecht & Crisp³ argue that “in theory, the current health system provides universal coverage. Yet, from a service delivery, resourcing and quality perspective, the distribution and level of services is inequitable with many communities and patients experiencing great difficulty in accessing the public health system.”

“The implementation plan for universal coverage must improve all dimensions of the health system. These dimensions include the ‘breadth’ (number of people protected), the ‘height’ (proportion of costs covered), and the ‘depth’ (range of services and benefits covered), as well as those additional factors that influence quality and safe services that contribute to improving health status.”

The authors conclude that the “NHI will require a far more efficient and effective health system than is currently the case. ... Reaching agreement on the financing system and its management is a crucial requirement but there are more immediate challenges, fundamental to a successful national health system, which must be addressed in the meantime.” The importance of their chapter in the SAHR 2010 is that it describes the practical reforms which are needed in the existing public health system which will contribute to improving all three dimensions of universal coverage.

“[R]eforms to achieve universal coverage must adequately address the following parameters:

- **Breadth** – increasing the number of people protected by the health system, including addressing physical, financial and access limitations. ... Strategies may include increasing the staffing levels of primary health care (PHC) facilities, changing opening times of clinics, encouraging and rewarding collective and integrated group practices, changing policies to encourage task-shifting or task-sharing, building more clinics, expanding mobile outreach services and home-based care, subsidising transport to and from health facilities and expanding patient transport services.
- **Height** – increasing the proportion of costs covered by pre-financing (more funding and less waste). These may include a range of financing options but for purposes of this chapter include improving procurement and administrative efficiencies, together with using the inputs of other sectors and departments that impact on health determinants, such as water and sanitation, education and human settlements.
- **Depth** – increasing the range of services and benefits covered by the system. Service packages for various levels of care, aligned to local burden of disease, will define access and related services. This may require changes in facility staffing to allow a greater range of services to be provided at designated PHC service delivery points, task-shifting or task-sharing to reduce the time costs of highly skilled professionals (including shifting nursing tasks from professional nurses to nursing assistants and from doctors to nurses and other assistants) and spending more on health services than in the past. Debate is necessary on the scope of the essential service package and on initiating periodic reviews of the package.

^b Dr Beth Engelbrecht is the Deputy Director-General: Specialised and Emergency Services in the Department of Health, Provincial Government of the Western Cape.

^c Dr Nicholas Crisp has extensive experience of the public sector and was head of the team that prepared reports on problems in the health service in the nine provinces in early 2009 for the then-Minister of Health, Barbara Hogan.

<http://www.section27.org.za/2010/09/03/reports-of-the-integrated-support-teams/>

<http://www.benguelahealth.com/profile/directors/BenguelaHealthGroup/tabid/56/Default.aspx>

5. The Policy for Subsidies in the National Health System

The degree to which the cost of healthcare is covered in the NHS affects the height axis in the universal coverage diagram for the two public NHS blocks. In the early 2000s the cost differences to the public for obtaining care in different provinces was relatively chaotic with the level at which the subsidy was implemented (on income and assets) differing according to provincial boundaries. However the work by the Department of Health to implement the Uniform Patient Fee Schedule (UPFS)^d since 2000 has produced a much more ordered set of subsidies.

“The first version of the Uniform Patient Fee Schedule was published in April 2000. It aims to provide a consistent approach to billing of hospital services in public hospitals. All provincial departments of health have committed themselves to the use of the Uniform Patient Fee Schedule through a process of consultation and policy development over ... 6 years.” However there can still be differences in timing in the month in which the annually-revised schedules are implemented.

The UPFS is applicable to all patients in the NHS provincial health facilities. However various levels of subsidisation of the UPFS apply with patients broadly defined in the following categories²⁷:

- **Full Paying Patients:** are liable for the full UPFS rates. It includes those receiving external funding from a medical scheme, the Road Accident Fund or under the Compensation for Occupational Injuries and Diseases (COIDA) Act. It also includes patients treated on the account of another government department, a foreign government or any other employer. A patient treated by their own private practitioner in a public health care facility pays the full facility fee component for services by the private practitioner and the full UPFS fee for any other service. Certain categories of non-South African citizens are also included in this category.
- **Subsidised Patients:** are further categorised based on their ability to pay for health services into four categories: H0, H1, H2 and H3. The fees payable by each category are expressed as a percentage of the full UPFS.
 - **H0:** Social pensioners and those receiving any type of social grant; formally unemployed people supported by the Unemployment Insurance Fund (UIF); and anyone who is unable to pay can be re-classified as H0 by the person in charge of the health care facility. These patients are fully subsidised and do not pay any fees.
 - **H1, H2 and H3:** the level of subsidisation depends on the assessment of income (the “means test”). The income cut-off between H1 and H2 is set at the 80th income percentile determined by StatsSA^e. The cut-off between H2 and H3 is the 90th percentile^f. “This is to encourage those individuals to take out medical aid”. The subsidies are large, for example with **H1** patients paying 20% for consultations but only 1% of the UPFS general ward day tariff, summed for 7 days for each 30 days in hospital, regardless of the level of intensity (e.g. ICU, high care or general ward). **H2** patients pay 70% for consultations and 7% per day for in-patient stays, with differentiation by bed type. **H3** patients pay full UPFS fees.
- **Free Services:** there are certain circumstances which have a statutory basis under which patients will receive services free of charge. This applies only to the episode of care directly related to the circumstances. For example, there are free health services for pregnant women and children under the age of 6 years (but not if they are members of a medical scheme); free primary healthcare services (as defined); free termination of pregnancy; care for those treated under the Child Care Act and the Mental Health Act; some circumstances described in the Criminal Procedure Act; and for some infectious or notifiable diseases.

^d See the UPFS site at: <http://www.doh.gov.za/programmes/upfs-f.html>

^e The DoH thus intends that “80% of employed individuals earn less than the cut-off amount per annum”. Currently this is a yearly income of R36,000 for a single person or R50,000 for a household.

^f R72,000 pa for a single person and R100,000 pa for a household.

Very little has been written about the impact of this subsidy policy on individuals and families. A rare exception is the 2009 paper by Goudge *et al*²⁸ which sets out to “measure the direct cost burdens (health care expenditure as a percent of total household expenditure) for households in rural South Africa ... in a setting with free public primary health care and hospital exemptions for the poor”.

The authors found that “On average, a household experiencing illness incurred a direct cost burden of 4.5% of total household expenditure. A visit to a public clinic generated a mean burden of 1.3%. Complex sequences of treatments led 20% of households to incur a burden over 10%, with transport costs generating 42% of this burden. An outpatient public hospital visit generated a burden of 8.2%, as only 58% of those eligible obtained an exemption; inpatient stays incurred a burden of 45%.”

“Consultations with private providers incurred a mean burden of 9.5%. About 38% of individuals who reported illness did not take any treatment action, 55% of whom identified financial and perceived supply-side barriers as reasons.”

The authors concluded that the “low overall mean cost burden of 4.5% suggests that free primary care and hospital exemptions provided financial protection. However, transport costs, the difficulty of obtaining hospital exemptions, use of private providers, and complex treatment patterns meant state-provided protection had limitations. The significant non-use of care shows the need for other measures such as more outreach services and more exemptions in rural areas. The findings also imply that fee removal anywhere must be accompanied by wider measures to ensure improved access.”

It is difficult to get details on the amounts paid by patients in each province and whether the collection is happening efficiently throughout the country. The experience of medical schemes of not always being billed for stays in public hospitals is one of the indications that the fee policy may not be fully implemented as intended in all provinces.

Any attempt to increase universal coverage in the NHS component must thus carefully consider the UPFS and UPFS subsidisation, as well as the factors identified by Goudge *et al*.

6. ILO Policy on the Use of Multiple Financing Mechanisms

With the multiple parts to the health system in South Africa, what should be the way forward? A very useful document is the International Labour Organization (ILO) paper entitled “Strategy towards Universal Access to Health Care”²⁹. The ILO says: : In view of the alarming deficit in social health protection coverage in many countries and ILO’s long experience in this field, a new strategy has been developed with the aim of contributing to achieve universal coverage at a global level. ... The new strategy responds to the needs of uncovered population groups in many developing countries, the informalization of economies and persisting high rates of unemployment. The approach explicitly recognizes the contribution of all existing forms of social health protection and optimizes their outcomes with a view to achieving universal coverage.”

“Financing mechanisms of social health protection range from tax-funded National Health Service delivery systems to contributions-financed mandatory social health insurance financed by employers and workers (involving tripartite governance structure) and mandated or regulated private non-profit health insurance schemes (with a clearly defined role in a pluralistic national health financing system comprising a number of different subsystems), as well as mutual and community-based non-profit health insurance schemes.”

“Each financing mechanism normally involves the pooling of risks between covered persons, and many of them explicitly include cross subsidizations between the rich and the poor. Some form of cross subsidization between the rich and the poor exists in all social health protection systems, otherwise the goal of universal access cannot be pursued or attained.”

“Virtually all countries have built systems based on various financing mechanisms that combine two or more of these financing options. ILO's social health protection policies explicitly and pragmatically recognize the pluralistic nature of national health protection systems and advise governments and other key players in social health protection to pursue strategic systemic combinations of national financing systems ...”.

“The financing of social health protection is therefore a mixture of taxation and contributions to public and mandated private insurance. Through risk pooling, these funds provide for equity, solidarity and affordability of services.”

“The overall objective of national policies in social health protection should be to develop a pragmatic strategy aimed at rationalizing the use of various health financing mechanisms with a view to achieving universal coverage and equal access for all. It is suggested here that countries develop their strategies towards universal coverage by:

- first, taking stock of all existing financing mechanisms in a given country;
- next, assessing the remaining access deficits, and
- last, developing a coverage plan which fills gaps in an efficient and effective way.”

“The State should play a pivotal, active role as facilitator and promoter in this context and define the operational space for each subsystem. This entails developing an inclusive legal framework and ensuring adequate funding and comprehensive benefits. The framework should also regulate voluntary private health insurance, including community-based schemes and consider regulations to ascertain good governance and effective protection. This framework establishes a rights-based approach to social health protection that refers in particular to the objective to include the uncovered part of the population in line with their needs and capacity to pay. The ILO also advocates a strong role for the social partners, particularly through social dialogue and broad participation in policy processes and governance of schemes including the social partners, civil society, the insured and other stakeholders in social health protection.”

“When developing the coverage plan all options of financing mechanisms – including all forms of compulsory and voluntary schemes, for-profit and non-profit schemes, public and private schemes ranging from national health services to community-based schemes – should be considered if they contribute in the given national context to achieving universal coverage and equal access to essential services for the whole population.”

“The coverage plan aims to provide a coherent design of pluralistic national health financing coverage and delivery systems consisting of subsystems such as national and social health insurance schemes, private insurance schemes, tax-based benefits, etc. for universal coverage that operate within a clearly defined scope of competence and cover defined subsections of the population. The objectives of the coverage plan thus comprise:

- determining a covering subsystem for all population subgroups;
- determining the rules governing the financing mechanisms for each subsystem and the financial linkages between them (also as financial risk equalization between different subsystems, if any); [emphasis added]
- developing adequate benefit packages and related financial protection in each subsystem;
- maximizing institutional and administrative efficiency in each subsystem and the system as a whole; and
- determining the time frame in which universal coverage will be reached.

“An approach to apply pluralistic financing mechanisms simultaneously to achieve the stepwise extension of effective social health protection coverage through national health services, social health insurance, community-based insurance and mandated private health insurance is the most promising strategy for attaining universal coverage. It represents an integrated approach, respects existing coverage and financing arrangements, and can be adjusted to the specific social and economic context of each country.”

7. A Potential Equitable Subsidy Framework

The diagrams below are a first attempt at how to bring the separate subsystems in South Africa together in a unified and equitable financing framework. Conceptually, the amount raised from taxes from the whole population (by means of income taxes, corporate taxes, VAT and other forms of tax⁹) should be applied equally across all the subsystems. For some subsystems, like the public National Health Service, this should be all the funds needed. It would be useful to set the common per capita amount to be equal to the amount determined to be needed for the NHS in any given year.

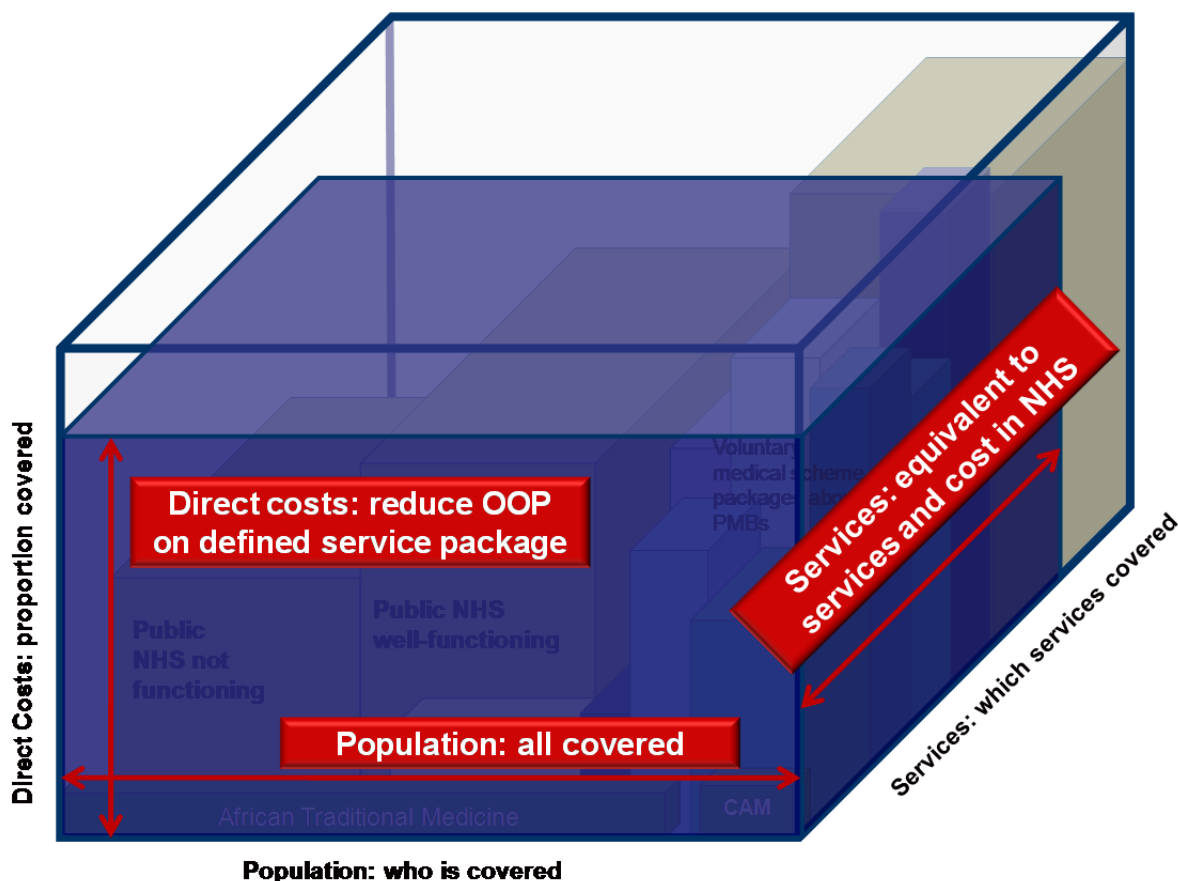


Figure 4: The Amount to be Financed Across All Health Subsystems

The NHS per capita amount will not cover the total cost of PMBs in medical schemes. This was a key understanding in the plans for social health insurance until 2007 and the balance was to be raised in the form of a social security contribution from those who benefited from the more expensive cover. A common per capita amount across all subsystems will also deal with the identified problems with the tax break given for medical scheme membership, as discussed in detail in section 4 of Policy Brief 7⁸.

⁹ The South African Revenue Service (SARS) lists all the tax types as follows: Air Passenger Tax (APT); Capital Gains Tax (CGT); Diamond Export Levy; Donations Tax; Estate Duty; Excise Duties and Levies; Mineral and Petroleum Resource Royalty; Income Tax (IT); Pay As You Earn (PAYE); Provisional Tax; Retirement Funds Tax; Secondary Tax on Companies (STC); Securities Transfer Tax (STT); Skills Development Levy (SDL); Stamp Duty; Transfer Duty; Turnover Tax; Uncertificated Securities Tax; Unemployment Insurance Fund (UIF); and Value Added Tax (VAT). See <http://www.sars.gov.za/home.asp?pid=161>

The diagram below shows how such a system might be organised. Taxes are raised from the population by SARS and become available as Government funding. Conceptually, the amount budgeted for healthcare should be linked to the health needs of the population. It was shown in section 4 of Policy Brief 1³⁰ that the population is expected to be gradually aging and that this means an increase in the amount needed of 10.2% between 2009 and 2025, before adding the effects of HIV/AIDS. The burden of disease will increase as the population ages and there is the specific effect of the development of the HIV/AIDS epidemic on future health costs³¹⁻³⁴.

The amount thus determined to be needed for healthcare could conceptually be paid to a National Health Solidarity Fund and then allocated to the various subsystems. The diagram below shows an allocation to only the NHS and to private health insurance funds, but the model is readily extended to include other subsystems like bargaining council funds¹¹ and LIMS^(forthcoming).

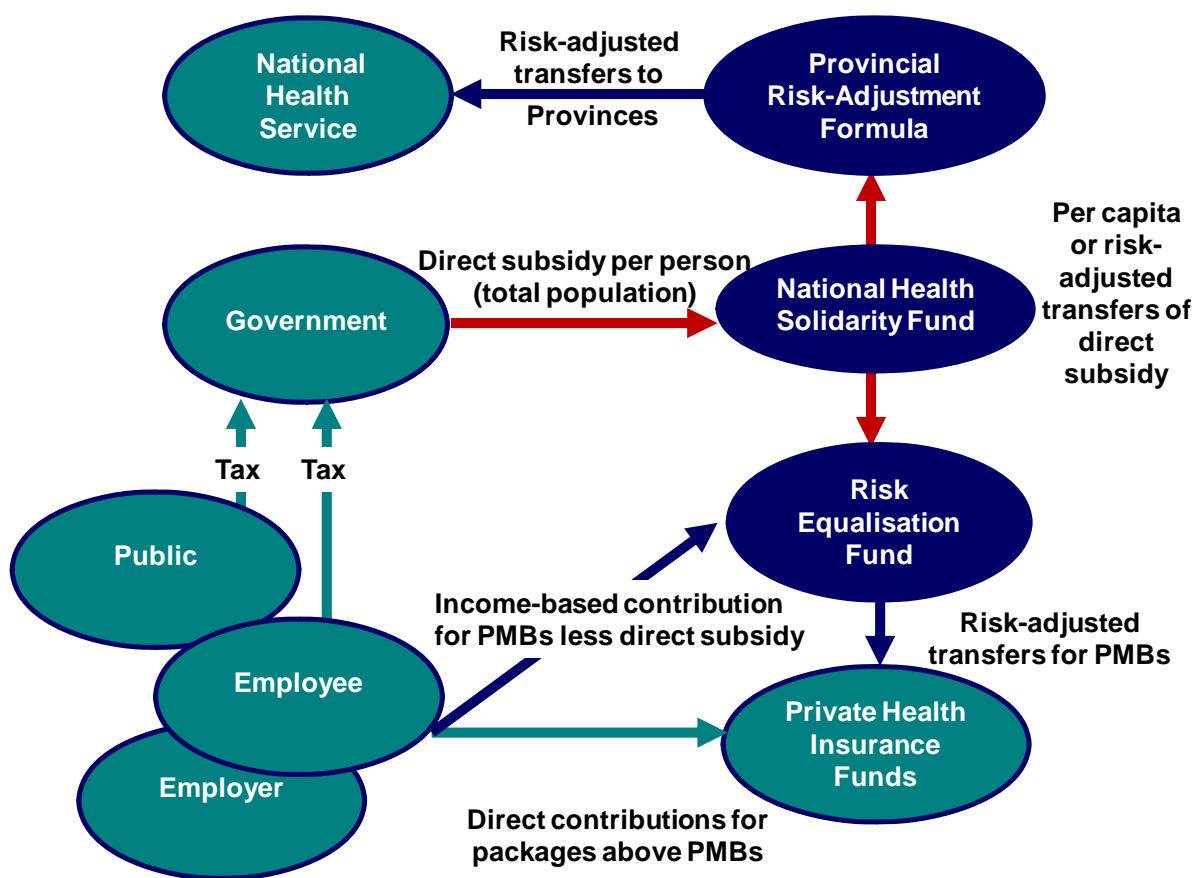


Figure 5: A Means of Financial Linkage between the Healthcare Subsystems in South Africa

The diagram shows the allocation of funds to the NHS where a further risk adjustment mechanism is needed. National Treasury has already worked with the Department of Health on a risk-adjusted capitation formula for the provinces and this is expected to be implemented in April 2011. The need to take account of gender and age differences in such a formula was illustrated in section 3 of Policy Brief 1³⁰, while the differential impact of HIV/AIDS on the provinces was shown in Policy Brief 4.³³

The need for a risk-adjusted formula for payment to medical schemes has been well-documented^{22,35}. The plans for implementation of a Risk Equalisation Fund (REF) were far advanced when enabling legislation was prepared for Parliament in 2008³⁶. The need for REF is still as acute as ever and it is hoped that the enabling legislation can be re-submitted at the earliest opportunity.

While much of the work has focused on the formula for paying risk-adjusted subsidies to medical schemes, a core element that must accompany the reforms is the income cross-subsidy for the balance of the price of PMBs. If this is not implemented simultaneously, there will be very adverse consequences for lower income families, as shown in Policy Brief 12³⁷.

As noted above, the mechanism for allocation can be notional. National Treasury is already responsible for the budgeting for healthcare and has worked on a risk-adjustment formula for allocation to the NHS in the provinces. The allocation of the per capita subsidy to REF (and any other subsystem) could likewise be done as part of the same function.

An issue that still needs to be explored is whether the transfers from the National Health Solidarity Fund should be made to the subsystems on the basis of a per capita allocation or whether this should be on a risk-adjusted basis. This needs further technical work to be completed before recommendations can be made.

Produced for IMSA by
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Resources on the IMSA Web-site

The following is available on the NHI section of the IMSA web-site: www.imsa.org.za

- The slides used in this policy brief [PowerPoint slides].

As the purpose of this series is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system, we would be delighted if you make use of it in other research and publications. All material produced for the IMSA NHI Policy Brief series and made available on the web-site may be freely used, provided the source is acknowledged. The material is produced under a Creative Commons Attribution-Noncommercial-Share Alike licence.



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