DRAFT COSATU POSITION PAPER ON NATIONAL HEALTH INSURANCE

1. AIM

The purpose of this paper is to provide a summary of critical insight into the challenges facing the South Healthcare System. It provides an analysis of the evolution of healthcare reforms pertaining to the National Health Insurance that were developed and implanted since 1994. It also gives a position on what COSATU as a Federation envisages as a fair, equitable and just system of healthcare financing and service provision, purchasing and administration in a unified healthcare system for all South Africans. The paper locates and highlights the vital aspects that are essential in a National Health System funded through a National Health Insurance.

2. VISION

Every person has the *right to achieve optimal health*, and it is the responsibility of the state to provide the conditions towards achieving this. The country needs a healthcare system that all people, regardless of class or status can depend on, and not just based on what you can afford to pay to access healthcare.

3. INTRODUCTION

Health care is a basic human right and should be aimed at rectification of the injustices of the past, addressing the current reality of poverty and inequality. South Africa's mission is to improve health status through prevention and promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability. Ultimately, to achieve the objectives of access, quality and equity, the country must transform towards the radical redistribution of healthcare resources.

The democratic elections in 1994 occurred within the international context of health policy dialogue that focused on efficiency considerations based on neo-liberal macro-economic policies in an environment of resource constraint. South Africa however, adopted more progressive pro-equity health policies informed by the Freedom Charter, the National Health Plan (The Green Book) and the Constitution of the Republic of South Africa through the Bill of Rights[1]. The Reconstruction and Development Programme (RDP) of 1994. In addition, the

[1] The Constitution of the Republic of South Africa, 1996, page 13

evolution of the Right to Health is also premised on the following international principles:

- ❑ Universal Declaration of Human Rights (Section 22- Right to Social Security)
- ❑ SADC Charter on Social Security
- ❑ Abuja Declaration that requires that Governments in Africa to allocate 15% of Government expenditure to Health

Several policies were adopted, legislative frameworks were promulgated, discussions were held and various committees were set up, as the commencing step towards overall restructuring of the South African national health system. These policies and arrangements contributed towards the crafting of a vision of a comprehensive, efficient, accessible and equitable National Health System (NHS). They include:

- 1998 White Paper for the Transformation of the Health System in South Africa
- Comprehensive Primary Health Care system
- National department of health's 'Ten Point Plan'
- Hospital Revitalization Program
- District Health System
- HIV/AIDS Strategic Plan

National legislative reform also included the Medical Schemes Act (1998) and the National Health Act (2003).

4. THE EVOLUTION OF HEALTH POLICY REFORM POST-1994

When the democratically elected ANC-led government took over in 1994, it was faced with many challenges, one of which was the state of health care services and the health status of the majority of the people of South Africa. The legacy of apartheid in health was characterized by inequalities, poor quality and inequitable access to health care for the disenfranchised majority of South Africans as indicated by their poor health status[2].The previous apartheid governments' legacy to health care was a weak, fragmented system that focused on urban areas and individuals who could afford private health care. The government through the state institutions has the stewardship responsibility of providing healthcare services to more than forty two million people or 84% of the population. The population that currently qualifies for this service is made out of predominantly the indigent, rural, low-income earners and the unemployed.

[2]A National Health Plan for SA -African National Congress, 1994, page 29

The African National Congress published a National Health in 1994 which amongst advocated other things for equity in health, the right to health and a national health system[3]. Health insurance was included as an important financing reform and the National Health Plan recommended that a Commission of Enquiry into a National Health Insurance System be appointed as a matter of urgency[4] to investigate equity in the health system. In addition to the National Health Plan, the African National Congress in consultation with its Alliance Partners and civil society adopted the Reconstruction and Development Programme (RDP) which advocated for the complete transformation of the healthcare delivery system[5] and the review of all relevant legislations, institutions and organizations to redress the harmful effects of apartheid in order to "Meeting Basic Needs" of South Africans.

Following the democratic elections in 1994, the Minister of Health appointed a Committee of Inquiry into a National Health Insurance System in January, 1995 (Broomberg & Shisana, 1995). The purpose and mandate of the Committee was to present proposals that would be interpreted as part of a broader and continuing restructuring and transformation of the entire health system. The context under which this Commission was constituted in 1995 was informed by notions of a controlled global health sector expenditure and redistribution of resources.

The Broomberg-Shisana Commission made recommendations to the Minister of Health, to phase out private health care funding within the next five to ten years of ANC government getting into power. The Commission also avoided making explicit recommendation on funding and left the decision to Cabinet and its Social Partners[6].

Whilst the National Health Plan favoured the UK-style tax funded National Health System, by the early 1990's, most analysts favoured a National Health Insurance System that covers the entire population with mandatory contributions .The view within the Department of Health was an inclination towards national health insurance as a financing mechanism. However, during the period between 1994 and 1996, the de facto health financing mechanism was Social Health Insurance[7] as a result of a well established private medical insurance industry. The private health insurers also had strong administrative expertise to run a health insurance schemes and political strength to oppose health reforms[8].

[3] A National Health Plan for SA, 1994, page 19
[44] A National Health Plan for SA, 1994, page 77
[5] The Reconstruction and Development Programme, 1994, page 43
[6] Report of the Committee of Inquiry into National Health Insurance System, 1995
[7] South African Health Review 2000, Doherty, McIntyre & Gilson, 2000
[8] South African Health Review 2000, Doherty, McIntyre & Gilson, 2000

Further commissions of inquiry into an envisaged funding model were established in 1997 to develop further a policy on health financing These Commission was dominated by technocrats, academic analysts and private sector whilst the trade union movement was not invited to participate[9] in the deliberations.. The 1994 Healthcare Financing Committee with policy advisors such as international agencies and local advisors[10] such as the Dr Henry J. Kaiser Family Foundation from the United States of America and consultants such Dr J.S Deeble from Australia were utilized extensively by the Department of Health (DoH) to develop and evaluate alternative models of funding. It was however in 1997 that the concept of National Health Insurance was formally replaced by the introduction of Social Health Insurance for South Africa[11] by the DoH. The SHI would be voluntary and cover and benefit a portion of the formally employed.

The 1997 SHI Working Group[12] and 1997 Medical Scheme Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act (MSA) in 1998. The MSA was legislated as an instrument for regulating the private health insurances. The MSA obliged private health insurers to accept all prospective members regardless of their health risk whilst SHI covered hospital care only for those in formal sector employment who were not covered by private health insurance[13] and who were earning above a certain income threshold.

National Treasury in line with Growth Employment and Redistribution (GEAR) Policy was opposed to both SHI and MSA. Treasury was concerned that SHI would raise further tax burden on the middle class, and which would be outside treasury's control. Treasury also objected to the proposed regulation of the private medical insurance industry through the MSA, as National Treasury placed high priority on the growth of the private sector and the private medical industry[14].

Despite the advise from the technical analysts and academic analysts, the then Minister of Health between 1994 and 1999, had reservations about the benefits of SHI as it would only cover a portion of the population and supported an NHI approach as a vehicle to achieve equity[15].

The trade union movement including COSATU was excluded in all the committees which dealt with SHI debates and this exclusion resulted in the 1997

[9] Actor Management in the development of Health Financing Reform, Thomas and Doherty, 2004
[10] The Report of the Committee of Inquiry into a National Health Insurance System acknowledges International agents used namely: The UK Overseas Development Administration, the Australian Development Agency, and the Henry J. Kaiser Family Foundation. International consultants acknowledged include: Prof Alan Maynard, Dr Wilbert Bannenberg, Dr Jonathan Deeble (Australian Development Agency), Prof William Hsiao and (Kaiser Foundation)
[11] South African Health Review 2000, Doherty, McIntyre & Gilson, 2000
[12] Actor Management in the development of Health Financing Reform, Thomas and Doherty, 2004
[13] Actor Management in the development of Health Financing Reform, Thomas and Doherty, 2004
[14] Actor Management in the development of Health Financing Reform, Thomas and Doherty, 2004
[15] Actor Management in the development of Health Financing Reform, Thomas and Doherty, 2004

ANC Conference not adopting the SHI policy. In 2000, the COSATU 7th National Congress adopted a resolution that reaffirmed its fight for a National Health Insurance (NHI) programme. COSATU also objected to SHI implementation, as the policy would make the poor working class pay for the poorest in society whilst the redistributive principles of social solidarity and cross-subsidization were not taken into consideration when SHI and MSA were developed. The ANC 2007 Polokwane Conference Resolution on Health reaffirms the implementation of NHI and states: *"To reaffirm the implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding".*

5. COMPREHENSIVE SOCIAL SECURITY SYSTEM

A Committee of Inquiry into a Comprehensive System of Social Security commonly known as the Taylor Committee was tasked by Cabinet to investigate various social security aspects of the South African Health care System in 1997. The Taylor Commission presented its recommendations to the Minister of Health in May 2002 on the future financing of the health care system in South Africa. The Taylor Commission report recommended that South Africa adopts ultimately a National Health Insurance that would integrate the public and private medical schemes in a universal contributory system (McLeod, 2004 and Doherty, McIntyre & Gilson, 2000). The Health Reform Timeline recommended by the Taylor Commission describes four phases of private health sector reform which were aimed at developing SHI for South Africa:

- Phase 1: Development of an enabling environment focusing on improving public health facilities and their management;
- Phase 2: Implementation of preparatory reforms through quality and cost-effectiveness of cover of voluntary, private medical schemes (MSA and its amendments);
- Phase 3: Implementation of initial mandates namely mandatory schemes for civil servants, statutory mandates for higher income earners and voluntary contributions for lower earners (GEMS and MSA Bill); and
- Phase 4: Implementation of a National Health Insurance Scheme in which the country could choose to remain with SHI or establish a National Health System where the NHI with mandatory cover falls within a universal non-contributory system.

It is evident from the evolution of the Medical Scheme's Act and SHI that principles espoused by the National Health Plan of the ANC were deviated from. This is as a result of inequitable healthcare financing legislations and policy instruments, as well as inefficiencies in administration mechanisms of private healthcare funds

6. CHALLENGES OF THE CURRENT REFORM PROCESS

South Africa is classified as a middle income country and it spends a total of 8.5 % of its GDP on health expenditure. South Africa has been a consistent with its health spending at around 8.5 % of GDP since 2002. This compares favorably with other similar countries classified as middle income countries in developed and developing economies. However, despite this high spending on health services South Africa's health system is ranked 175th within the world ranking (WHO, 2000). Performance was dragged down with regard to scoring on responsiveness and fairness in financial distribution, showing that despite the availability of adequate financial resources, South Africa's health system is performing poorly.

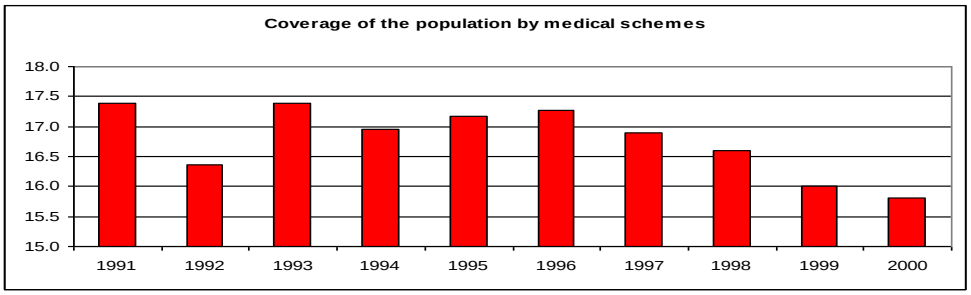
These are reflected in the continued challenges experienced within the health system, thus compromising on the attainment of the goal of better health and better life for all. Therefore despite interventions towards improving access to health services, the burden of disease and mortality in South Africa has been growing. The system is characterized by a growing burden of disease due to HIV/AIDS pandemic, worsening health status indicators, the resurgence of communicable diseases and inadequate human resource provisioning. Currently the public-private sector disparities and the nature of the interface, or lack thereof, serve as major impediments to an equitable and sustainable health system. There is clearly failure of the market to ensure that healthcare, which is a basic human right is universally accessible to all citizens in South Africa.

6.1 COMMODITIZATION AND STRATIFICATION

The South African health system continues to be fragmented and this is entrenched in law by the Medical Schemes Act (MSA, 1998).The current healthcare system is a multi-tiered system with funding of the healthcare system skewed in favour of those who can afford to pay. Consequently, an over resourced (in terms of financial, human and material means) and under utilized private sector is coexisting along side a public sector characterized by declining health budgets. The under-resourced public sector services 85% of the population, whilst the burgeoning commoditized and commercialized private sector caters to middle and high income earners who tend to be members on medical schemes (14.7% of the population). Private health sector costs have continued to rise exponentially whilst the number of members covered by private medical insurance has decreased from 18% of population covered in the early 1990 to 14% in the early 2000 as shown in Figure 1 below.

Figure 1

Medical Scheme Coverage



The number of members covered by private medical insurance has remained stagnant and is hovering at 7 million for the past five years as shown in Table 1 below.

Table 1

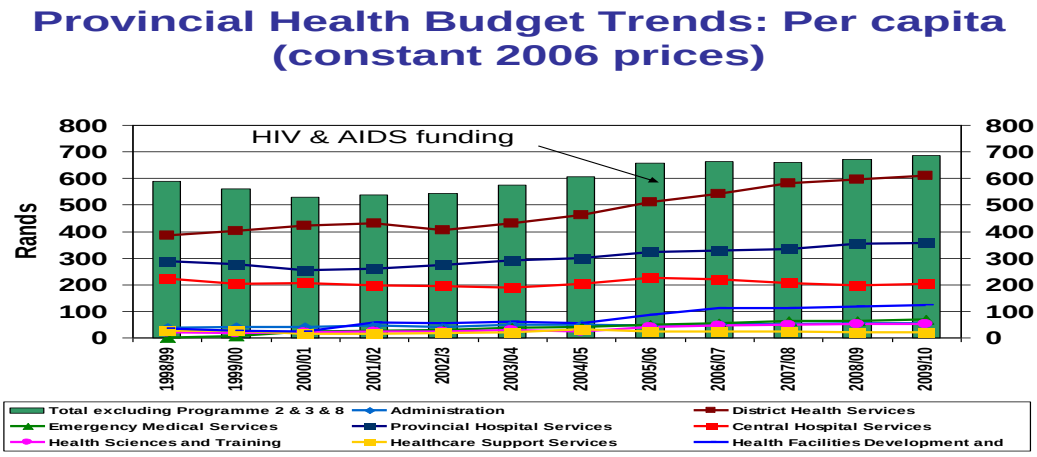
TRENDS IN MEDICAL SCHEME COVERAGE

Medical Aid coverage	2002	2003	2004	2007
Total population –Official (Thousand)	45533	46007	46459	48759
Number covered by a medical aid scheme (Thousand)	6923	6794	6902	7100
Percentage covered by a medical aid scheme	15.2	14.8	14.9	14.8

6.2 FINANCIAL MISALIGNMENT AND BUDGETARY CONSTRAINTS

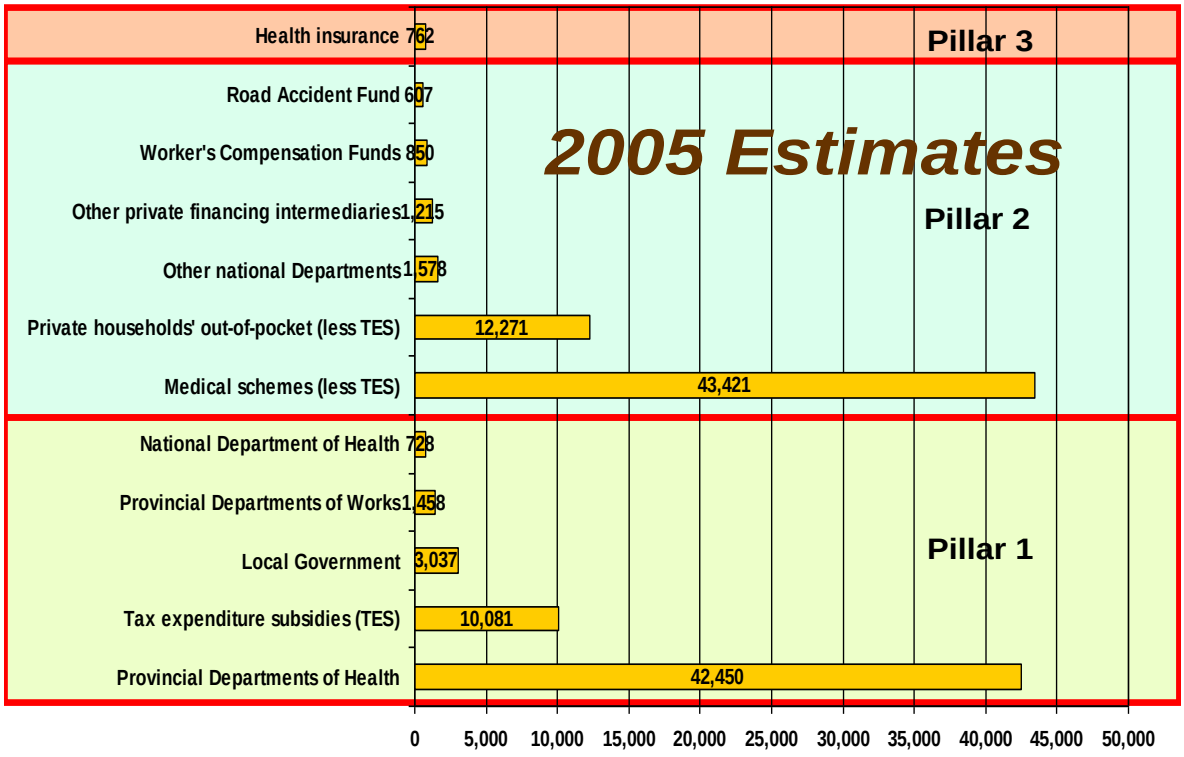
South Africa currently spends about R135 billion or 8.5% GDP on healthcare. Of this R59 billion (45%) is public health expenditure which serves 42 million people whilst the private sector spent R66 billion on 7,4million people. Government subsidizes the private medical insurance industry to an amount of R10 billion per annum. Public sector expenditure has been stagnating for several years as demonstrated in figure 2 below.

Figure 2



The patterns of disproportional expenditure in the healthcare system are illustrated in figure one below and indicate that there is a bias in financial resource allocation towards the private medical sector as shown in Figure 3 below.

Figure 3



Government allocates 11% of its total budget to health and this falls short of the

15% proposed by Heads of States of countries in the African Union, in 2005 known as the Abuja Declaration. This has hampered service provision and infrastructure development in the public health system.

6.3 HUMAN RESOURCE CHALLENGES

Health care delivery is a human-resource intensive sector and 60% of health budgets are spent on human resources. The key HR problems bedeviling public health care provision, in particular, are migration and inequitable personnel distribution (resulting in absolute shortages in some cadres and areas), inappropriate and inequitable training opportunities, low staff morale and weaknesses in skills and attitudes towards patients (Lehmann and Sanders 2004). More than 60% of professional human resources in health are in the private sector and also as a result of agentization. As of 2006, 29% of the public health sector posts were vacant. There is also a common understanding that the push factors associated with migration and retention problems, especially in the public sector, include poor human resource management and weak support for staff, work overload and emotional burnout, training that does not adequately address human resource requirements of the country or equip staff to work in rural and under resourced areas, problems of working conditions, including concern about staff safety and remuneration levels (Gilson et al., 2005; Lehman and Sanders 2004).

6.4 SHI VERSUS NHI

Table 2

Difference between NHI and SHI

National Health Insurance	Social Health Insurance
Implementation can be immediate or within a limited space of time	Implementation towards universal coverage is protracted and gradual
Provides necessary financial base for an NHS employer and employee contribution	Drains state resources into private sector by subsidization through tax relief
Funding through payroll levy tax and progressive taxation system	Co-payment; system of deductibles at point of payment
Establishes single provider of healthcare in country at different levels	Private health funding system remains as is and promotes stratification and duality
Coverage is universal for necessary medical services irrespective of ability to pay	Promotes PMB's – inadequate cover
Single administrative system but decentralized. Excludes wastage associated with brokers	Allows for duplication and multiplication of administrators and administrative systems; rising private sector costs; benefit exclusions. Does not address problem associated with brokerage fees.

Limitations of SHI as currently pursued in SA:

- Protracted and incremental development (up to 100yrs for SHI)
- Gradual systematic expansion-evolutionary
- Access as a determinant of need (A demand-side driven intervention, which focuses on what households are willing to prepay for a health benefit instead of supply-side intervention and redistributive fiscal interventions)
- Benefit allocation to wealthy and those employee (Benefit package differentials)
- Infrastructure and geographical access problems
- Structure of labour market and high unemployment rate
- User fees and co-payments

7. GUIDING PRINCIPLES

Health equity is founded on the notion of universality of greater good for the greater number of people based on Rawlsian principles of social-justice taking into account the social determinants of health. To advance the principles of social justice and universalism requires a return to the Rawlsian argument of vertical equity, procedural and distributive justice with fairness in outcomes and equality in opportunities. Any health system pursuing "*Access to Health for All"* should have the following tenets as a minimum that guides equity in healthcare include:

- **Political will and stewardship**
- **Social solidarity:** The health insurance plan must be determined and mandated by government's imperative to provide equal access to health care at an affordable cost, based on funding of a health insurance that is premised on the means to contribute. The benefits and their design thereof must be based on the needs of the patient/users of the service (and not the means to pay. This implies broader risk pooling and equitable benefits
- **Universal coverage**
    - ✓ Equity of access
    - ✓ Financial risk protection and adequate protection against the financial consequences of the use of health care system
    - ✓ Removal of financial barriers to the uptake of services
    - ✓ Accessibility without income barriers
    - ✓ Equality in opportunities
    - ✓ Universally available to all people living in SA
- **Vertical Equity:** Acknowledges that "unnecessary" or "avoidable" gaps in health and health care service delivery between groups with different levels of social privilege should be eliminated.
- **Health as a public good**
    - ✓ Decommodification of healthcare
    - ✓ Destratification of society
    - ✓ Publicly administered system

- **Efficiency**: Pooling of all resources (money, human resources, physical infrastructure, and equipment, medicine) together to ensure sustainability;
- **Comprehensive**: In the services it covers

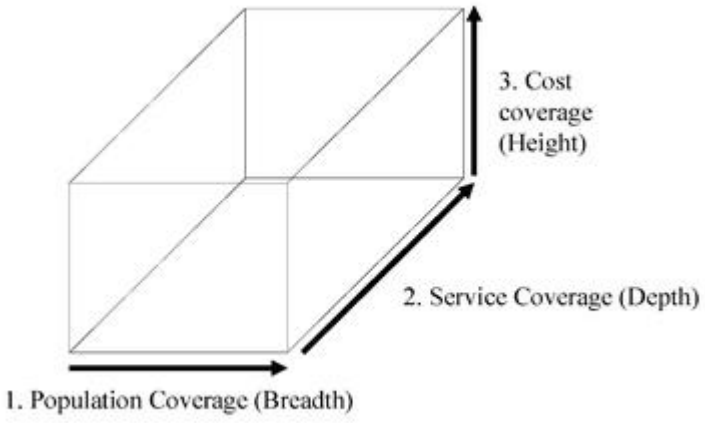
8. COMPREHENSIVE PACKAGE OF HEALTH SERVICES

Health is a public good and there is a need to restore confidence of society in public healthcare institutions and ascertain that the healthcare system benefits all people in South Africa. Healthcare in South Africa varies from the most basic primary health care to highly specialized hi-tech services. Basic primary health care is offered free by the state, whilst highly specialized hi-tech services are available at tertiary public institutions and in the private sector for those who can afford to pay for it.

8.1COMPREHENSIVE PACKAGE OF HEALTHCARE SERVICES

It is important to define a comprehensive package of healthcare services that will improve the overall health of South Africans by providing essential preventative and primary health care, and to address the major diseases and health issues that are the biggest contributors to death. The coverage of a given population for health services can be characterized in three dimensions: "breadth" as the extent of covered population, "depth" as the number and character of covered services, and "height" as the extent to which costs of the defined services are covered by prepaid financial resources as opposed to cost-sharing requirements. Figure 4 summarizes the three dimensions of a basic basket.

Figure 4

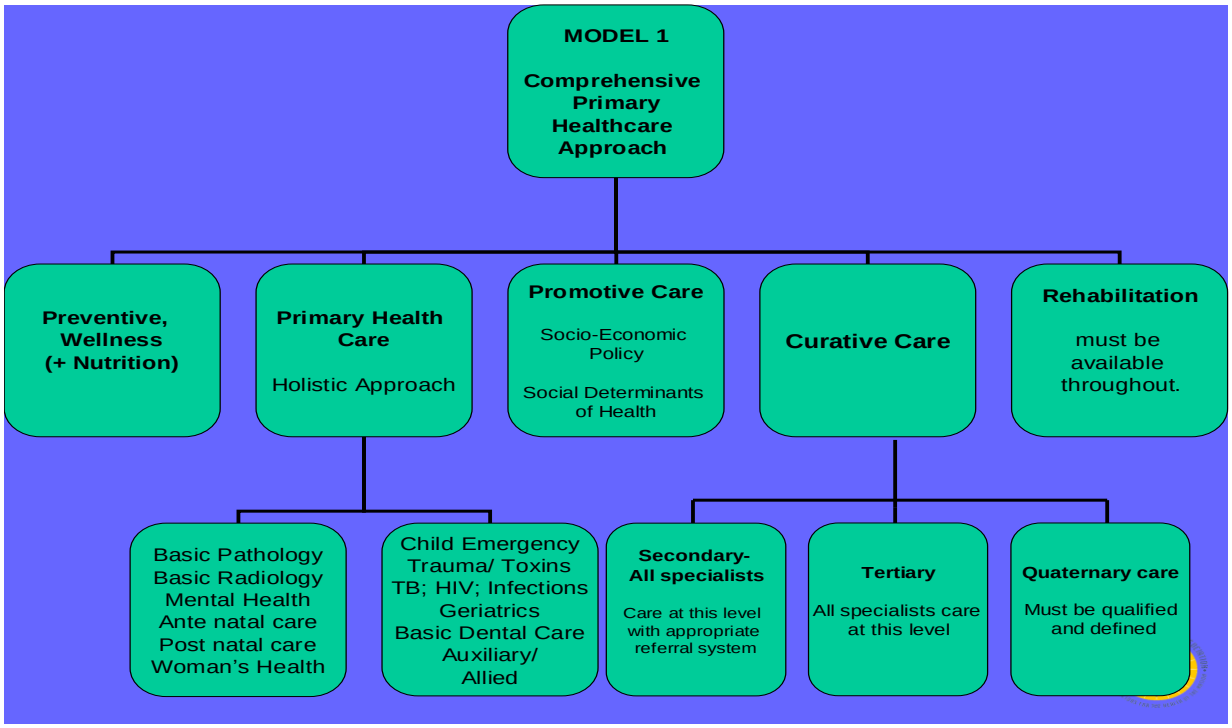


A comprehensive package comprises the core health and health related interventions that are promotive, preventive, basic curative, and rehabilitative services that are agreed to be necessary and which people can expect to receive

through the various health delivery mechanisms and points. The services and goods in a comprehensive healthcare package must include minimum compulsory benefits that all healthcare providers must cover. The package should/must include a primary care component (focusing on preventative programmes, mother and child care, oral health, curative, rehabilitative and promotive care), and a hospital component: secondary, tertiary and quaternary (includes medical and surgical management, oncology, radiology and pathology, medication, in-hospital care cost-effectively).

The package must be guided by the principle of need (equity) and not ability to pay and secondly on cost-effectiveness. Principles to consider when developing a comprehensive package of healthcare services is that it should address the notion of public and community interest such that all externalities are funded without co-payments and that maternal and infant care should be a high priority. Figure 5 below explains a model proposed and to be considered in the development of a comprehensive package of healthcare services for South Africa.

Figure 5: Comprehensive Package of Healthcare Services



A Comprehensive Package of Healthcare will require active inputs and stewardship role of the Department of Health, Treasury, labour and civil society. Legislative review of the current funding mechanisms of health services must be conducted to create an enabling legislation for common funding of the Comprehensive Package of Health Services. The basket must refer to the totality

of services, activities, and goods covered by publicly funded statutory/mandatory insurance schemes implemented through a National Health Services (NHS).

8.2 PRIMARY HEALTHCARE

South Africa has already done a lot in defining the basket of PHC services through the 1997 White Paper for the Transformation of the Health System. Primary health care as defined by the World Health Organization in the Declaration of Alma-Ata is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Primary health care approach must focus on prevention, curative, rehabilitation and promotion. Promotion addresses socio-economic policy and social determinants of health e.g. tobacco policy.

It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. It addresses the most common problems in the community by providing promotive, curative, preventative and rehabilitation services to maximize health and well-being and it is care that organizes and rationalizes the deployment of basic and specialized resources directed at promoting, maintaining and improving health.

Primary health care serves several unique and essential purposes:

- These services are usually located in communities, making them the first point of contact with the health system for many individuals;
- The services can handle a wide range of basic health conditions;
- Patients are followed over time by the same primary care providers;
- The services are coordinated with higher levels of the health system that can provide more specialized care when needed; and
- These services can reach out to marginalized and underserved groups that might not otherwise seek or receive health care.

Primary health care:

- Reduces the disease burden - by effectively addressing the most common health needs of children, primary health care can bring the greatest benefits to the health of families and communities.
- Produces economic efficiency **-** by improving family health, primary care services can reduce the economic consequences of ill-health.
- Assures greater equity - compared with higher levels of care, primary care services are more geographically, financially, and culturally accessible to local

communities, providing more personalized care to the poorest people who need it most.

Based on WHO guidelines, Primary healthcare should follow the following principles:

- It should be shaped around the life patterns of the population and should meet the daily health needs of the community;
- It should form an integral part of the national health system, and other levels of health services should support the primary health care services;
- Primary health care services should be integrated with other services concerned with community development, such as agriculture, communications and education;
- The local community must be actively involved with the health care activities;
- An integrated approach should be used and promotive, preventive, curative and rehabilitation services should be available;
- Treatment should be carried out by properly trained health care workers and should be as basic as possible; and
- There should be adequate facilities for prompt and efficient referral.

Factors critical to the success of primary care are:

- Every South African should have access to and be encouraged to select primary care practitioner;
- General Practitioners (GP) are the preferred point of entry into the primary medical care system. However, where there human resource constraint, primary care nurse practitioners can be used as a point of entry;
- The GP's role must include a number of responsibilities including provider of patients care, manager of patient's health records, case coordinator, patient advocate and promoter of health;
- The primary care system must strive for clinical excellence.

Primary Health Care should be simple and render an effective service that is accessible to all members of the community, which aims to upgrade and improve the living conditions of the individuals in that community. Primary Health Care should always be regarded as first and foremost, a community effort, and is most likely to be effective if the methods used are understood and accepted by the community.

8.3 ESSENTIAL HEALTH PACKAGE

An essential health package (EHP) refers to a set of cost-effective, affordable and equitable interventions for addressing conditions, diseases, and associated factors that are responsible for the greater part of the disease burden. An essential healthcare package can be defined as a plan that provides a minimum

compulsory set of benefits that should be covered by a health insurance. It is a set of basic entitlements to services that must be funded and provided for the benefit of all. An essential package consists of minimal compulsory set of benefits and exclusions are guided by cost.

The goal of delivering an EHP is to contribute to poverty reduction and sustainable development by promoting efficient, effective and equitable access to essential health services of the population, particularly the poor. If the EHP is not clearly defined, it may leave room for misinterpretation and conflict. The major guiding principles adopted for benefit inclusion are that it must:

- Embrace the policy initiatives of the National Department of Health (NDoH);
- Be aligned to WHO policies and recommendations for a developing country;
- Support efforts to promote continuity of care;
- Address the major burden of disease;
- Be clearly defined;
- Address the effects of moral hazard and anti-selection risk; and
- Be affordable

The EHP is developed taking into consideration the following values and principles:

- Cost effectiveness through selection of priority cost-effective interventions
- Affordability in terms of the country capacity to provide the services
- Equity to ensure equal access and utilization of health care according to needs
- Necessity which implies inclusion of services that when missed will have a disastrous and intolerable outcome as in the case of exposure to rabies
- Capacity in terms of human resources and organization
- Accessibility ensuring physical and financial accessibility of essential services

The objectives of defining and delivering an EHP are:

- To enhance the effectiveness of the health sector program. The development of an EHP will help improve effectiveness of the health sector program and its management by increasing attention towards health service output.
- To promote standardization of essential services. The EHP enhances availability and delivery of equitable services for each district by defining the minimum standard for each level of care. The access to this package by pastoralists and scattered communities will also be specifically handled. These help ensure equitable access to essential health services.
- To promote output / result oriented health service delivery.
- To serve as a management tool. The EHP will serve as basis for planning and management of health services, to guide resource allocation by the districts as well as for monitoring and evaluation of the performance of the health facilities.

EHP generally includes a primary care component (focusing on preventative programmes, mother and child care, oral health etc). Hospital component sometimes differentiated by hospital level: (secondary, tertiary and quaternary). Inclusion and exclusion criteria for EHP in developed and developing countries is guided by the first principle of need and secondly of cost-effectiveness. EHP is organized into the following five components:

- Family Health Services
- Communicable Disease Prevention and Control Services
- Hygiene and Environmental Health Services
- Health Education and Communication Services
- Basic Curative Care and Treatment of Major Chronic Condition

The package contains a list of health care services with restrictions on reimbursement such as cost sharing, maximum reimbursement, and exclusion of coverage for certain procedures or benefits.

8.4 BASIC BENEFIT PACKAGE (BHCP)

A standard, or basic, benefit package is a plan of health insurance coverage that providing standardized equitable access. The treatment necessity is guided by effectiveness (not costs) and the package may represent a minimum set of benefits to be equaled or exceeded by health insurance cover. It generally consists of a list of health care services required to be covered, along with limitations on reimbursement such as cost sharing, maximum reimbursement, and exclusion of coverage for certain procedures or benefits.

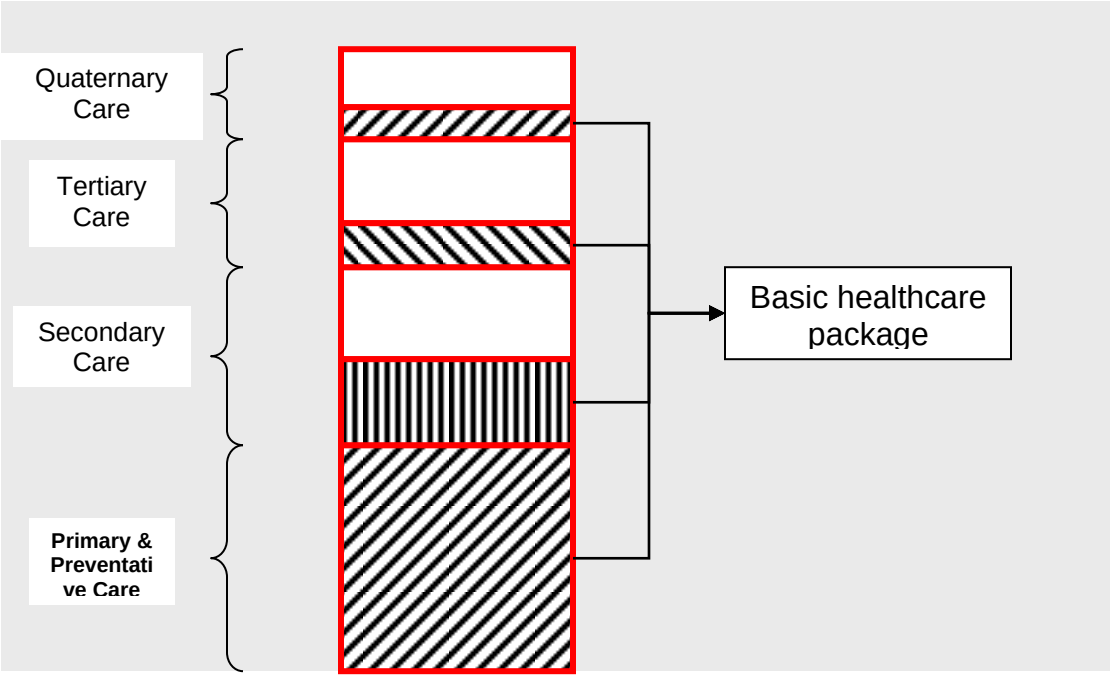
A Basic Benefit Package defines a minimum level of health services that should be available to all members of a population irrespective of their ability to pay and as mandated by government to assure adequate health status and protection of the population from disease or that meets some other criteria or standard.

The BHCP must be founded on the fundamental principles of social solidarity and risk pooling for the whole population and these principles should be applied to the total package of common benefits. There are many combinations of benefit packages that can make up BHCP and these should be carefully chosen to meet the needs of the whole population. Goals of a basic benefit package include:

- Providing a uniform basis for measuring and comparing the cost of health care plans,
- Providing a benchmark level of benefits for comparison with other plans, and
- Helping to control cost using economies of scale, cost-sharing and managed care.

Figure 6 below illustrates a basic healthcare package.

Figure 6



It is difficult to predict a basic benefit package's cost because of the complexity of benefit design; inadequate or conflicting pricing data; the impact of adverse risk selection; increased use of healthcare because coverage becomes available (induced demand); the effect of managed health care; and trends over time in utilization, price, and population demographics.

Designating a basic set of benefits can have the potential to eliminate or undermine comprehensive package healthcare services and discourage more imaginative approaches to benefit design. If too specific, it can generate controversy and debate over what will be covered. If too vague, it will be open to different interpretations by different health programmes, which could lead to benefit differences, adverse risk selection, and increased total cost of providing coverage. The basic package should include/ specify a comprehensive basket of key health conditions to be covered.

The private health sector currently has developed a package of benefits called prescribed minimum benefits (PMB's).The current list is not exhaustive and still needs to be developed further. Through the Council for Medical Schemes, South Africa has started to expand the list some of the common conditions including the common chronic conditions that must be included in the PMB list. While PMB's form an important part of the basket of services to be included in the BHCP, it is minimalist in approach and tends not to be comprehensive.

The BHCP often can have room for supplementary benefits over and above the basic package of healthcare services but the individuals are made to "buy up" supplementary services through the basic package. It is important to specify the appropriate funding mechanism for the suggested/proposed basic healthcare package to achieve universalism and equity.

9. TOWARDS A NATIONAL HEALTH INSURANCE

The central tenets of a National Health System, funded on a National Health Insurance (NHI), are that it is universally accessible and free at the point of service. South Africa's fragmented health care system is characterized by a number of features namely: That the funding system is distinguished by public sector funding through national taxes and donations from various sources, and a significant private sector in which private medical schemes are the predominant form of 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 (RAF), Compensation for Occupational Injuries and Diseases Act (COIDA) and Medical Schemes Act (including GEMS). An expanding public sector and the provider of last resort cater for approximately 85% of the population on a health budget of less than 44% of the total health expenditure. An NHI proposal should address the following key elements: Funding method, pooling of resources, administration, purchasing of services and service provision

9.1 FUNDING OF NHI

The NHI is Beveridge-based conceptions of health funding. It is derived from general tax revenue acquired either through income tax; corporate tax; and purchase tax such as value-added tax or general sales tax; property tax; capital gains tax; cigarette taxes; import duties or an NHI tax levy. The tax-based financing has been defined as a system in which more than half of public health expenditure is funded through revenues other than those earmarked payroll taxes. In contrast to SHI and private insurance, the NHI uses a broader and larger scope of mobilizing funds[16], from everyone in the population, regardless of health status, income or occupation, thus avoiding adverse selection[17] and risk selection[18].

NHI should be centrally-funded, based on an equitable progressive taxation system and cross-subsidization. A tax-funded NHI will enjoy the privilege of being able to provide universal access which covers the most vulnerable members of society especially the poor, the sick, the old and rural from financial

[16] Bennett & Gilson, 2001 and Savedoff, 2004
[17] The tendency for insurance to attract only higher risk individuals and thus raising average cost of insurance beyond reach of many people)
[18] The process by which insurers screen potential clients and only enroll those with lower health risks

shocks. The contributions are spread through a large share of the population. As a consequence, evasion of payroll taxes as a result of informalisation of labour and social insurance contributions will be capped[19]. A tax-based system benefits from economies of scale in administration, risk management and purchasing power.

A tax-based health financing mechanism is based on mandatory contributions and does not involve user charges or co-payments at point of services. It therefore improves access. The mechanism enjoys the privilege of being able to provide universal access which covers the most vulnerable members of society especially the poor, the sick, the old and rural from financial shocks[20]. Making health care universally accessible requires social mobilization and political willingness. Health systems in developing countries also have to be developed from a weak institutional environment. Solidarity and social mobilization impact on the establishment of a strong health system, necessary for the success of a tax-based health insurance. This would require that in addition to contributions, government's allocation of public health budget is increased from the current 11% to the 15% that has been proposed through the Abuja Declaration.

An NHI funded through a tax-based health financing system is pro-poor and is an imperative for developing countries, particularly where the formal employed sector represents a small fraction of the total population. The advantages of funding An NHI through a tax-based financing mechanism are that it ensures that access to publicly-financed health services is available to all citizens. The basket of healthcare services has to be funded through a health insurance plan determined and mandated by government's imperative to provide equal access to basic health care at an affordable cost.

9.2 POOLING

A central Authority should be established for the purpose of pooling financial resources called the NHI Authority. Its main function will be to receive and take control of the funds from all contributors in the system. It is at this level of the pipeline that modelling of risk, and mitigation thereof, should be operationalized. This Authority will therefore be the ultimate strategic overseer of all funding related to essential services, as defined by the 'comprehensive healthcare package'. Services additional to the comprehensive package will be regarded as supplementary; but since they will be voluntary (rather than mandatory), they will be therefore be funded and controlled outside of this system as a top-up. Members of the population who wish to access services other than those provided in the system will have a 'buy up' option that will be enabled by a voluntary co-existent private health sector, which will most likely be running

[19] Savedoff, 2004
[20] Bennett & Gilson, 2001

along market system principles. It is important for the state to use regulatory instruments to protect the national health system from being undermined or cannibalized by such parallel provisions – to ensure that parallel providers do not have the overall effect of ultimately draining resources from the national health system, e.g. professional skills.

9.3 ADMINISTRATIION

The role of the administrator is to register members, collect contributions, and to contract and reimburse service providers. Administration may be conducted by a single or multiple administrators established by statute. In a multiple administrator environment, competitive pressures escalate administrative costs due to marketing and advertisement costs. Although price competition amongst administrators has been accredited with improved efficiency and quality assurance, administration costs in the current South African private medical insurance industry are one of the key cost drivers of the private healthcare pie. Although there is a duplication of administrators, they currently consume approximately 13% of the private insurance costs. Navarro (1999) asserts that 25% of expenditure on health and medical care in the United States of America (USA) goes to administrators as compared to 6% in the Swedish National Health Service. The NHI will be administered by a single entity that is created by the NHI Authority. The NHI Authority must implement a single payer system thus reducing wastage of multiple administrations.

9.4 PURCHASING

Purchasing of services should either be conducted by the NHI authority or delegated to decentralized branches of the NHI authority. The actual transacting may cover a wide spectrum – from funding an existing public health system to contracting with various appropriate independent service providers. The key element of purchasing decisions is to base them on needs of healthcare recipients rather than means.

The operational aspect of purchasing should take advantage of the existing district health system and any other relevant regional structures and authorities. Therefore purchasing, financing and HR decisions should be decentralized while being fully accountable to the NHI Authority. Establishment of a strong governance structure, that will entrench norms and standards, must precede any transacting at this level. Purchasing must mandate minimum benefits and focus on catastrophic cover first but also incorporate out-of-hospital services. Purchasing will have to shift from fee for service reimbursement models to capitation, allowances under a contract model, global fees, per diem and DRG's. Careful consideration must be made to models of fee for service, given supplier induced demand and perverse incentives of other systems. The question that

must however be addresses is whether purchasing under NHI can overcome capitation under-servicing and improve quality of care.

9.5 SERVICE PROVISION

NHI utilizes a network of public and contracted private providers often referred to as the National Health Service (NHS)[21]. In the interim, both public and private sectors have a role to play and the system should transact with both public and private providers to ensure equitable use of existing resources. Services can be purchased from for the profit or not for profit sector if appropriate re-imbursement model are implemented. The services provided must contain hospital-based and community-based services and the general practitioner's must be the first contact for those seeking primary healthcare. Private sector service providers such as private hospitals should participate through a regulated contracting arrangement based on a not for profit models covering operational costs and a regulated mark-up as well as the needs of healthcare users through the promulgation of the Certificate of Need Section 36 of the National Health Act. There should be a comprehensive 'supply side' regulatory framework to ensure that providers are 'fit for purpose'.

For NHI Service Provision to succeed, the system must place a special focus on the production, retention and attraction of skilled health professionals as a way of ensuring the constant existence of a critical mass of healthcare providers. This is a critical strategic imperative that is essential for the success of a national health system funded on a National Health Insurance. Governance, management and efficiency of public health institutions must be revised and improved. This will also require strengthening of public sector: financing, systems, infrastructure, human resources etc. In the long term a national dialogue on a future National Health Service (NHS) must be address the following questions regarding public or private or private sector service provision:

- What type of model should be developed for the profit sector?
- Should the for-not-for profit sector of service provision be expanded?
- Should public service providers compete with private providers (profit and non-profit)?
- Can private providers really be trusted?
- Will big business and the well entrenched private sector providers ever flex their muscle (supply and demand)?

10 CONCLUSION

[21] Carrin & James, 2004

Although the original goals of reform of the South African health system were aimed at ensuring universal coverage for health, the market-orientated reforms of SHI and the Medical Schemes Act introduced between 1997 and 1998 moved away from notion of health as a public good funded from a National Health Insurance derived from a general tax revenue to more to commercial and privately funded health care systems. There is a need for trade-offs to protect all citizens and especially vulnerable communities and the poor from the risks of the marketplace within a capitalistic society through redistributive and equitable health policies and legislations. The key variables that define these trade-offs must be based on policy initiatives aimed at addressing class differences accentuated by market-place variables and democratic principles. These variables should determine how social citizenship, efficiency and equality, capitalism and socialism are defined. The country will achieve the objectives if transformation agenda directed towards:

- Redistributive policies for health care resource
- Considering health as an investment for RSA