



A critical analysis of the suitability of a national health insurance scheme in South Africa

**by**

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**Thesis submitted in fulfilment of the requirements of the degree.**

**Master of Technology: Public Management**

**in the Faculty of Business**

**at the Cape Peninsula University of Technology**

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**Cape Town**

MAY 2011

## DECLARATION

I, Zonique Lewore Mack, declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessary those of the Cape Peninsula University of Technology.

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Signed

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Date

## **ABSTRACT**

In South Africa's two-tiered health system, some enjoy health care based on ability to pay and others utilize services in an under-funded sector. The rift in the two, public and private sectors, primarily exists because income categories either curb or allow the necessary contributions. This thesis reports on the various contributing mechanisms, through which health care can be ensured universally, without causing impoverishment. The framework or criteria selected for this study includes feasibility, equity, efficiency and sustainability of a contributing mechanism. Furthermore, the contributing mechanisms – tax-funded, NHI, voluntary health insurance and out-of-pocket – are resident within four health care models namely, Beveridge, Bismarck, NHI and Out-of-pocket. These models are discussed as well as relevant country examples are provided. In the pursuit of answering whether the NHI scheme is suitable for South Africa, the study shows that government or tax-funding and NHI provides the contributing mechanisms that are applicable to the South African situation within the context of different challenges. It is recommended that, in the government's discussions about health care reform, prepayment, universalism and health care expenditure, amongst others, be considered.

## **DEDICATION**

This thesis is dedicated to my family, with love and in gratitude.

## ACKNOWLEDGEMENTS

I, hereby, would like to express my gratitude and appreciation to the following role-players who contributed to this research:

- Jesus Christ, for granting me grace, guidance, mercy and wisdom to do this dissertation.
- To my family, mother, father and two siblings who have been patient and understanding through the process of better positioning me for the future.
- To Dr Dassah, who, from inception, played a very important role as mentor by nurturing my ability as a researcher and assisting me to conceptualise this unique study.
- Thanks to Prof Ballard, for guidance with technical thinking and insight with regard to the research and qualitative research approach.
- I extend much appreciation to Mrs Bytheway for the editing and grammarian check of this paper.

The financial assistance of the Mauerberger Foundation Scholarship towards this research is acknowledged. Opinions expressed in this thesis and conclusions arrived at, are those of the author and are not necessarily to be attributed to the Mauerberger Foundation.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Introduction

The Republic of South Africa of 1996 establishes equity in health care, as detailed in Sections 27(1)(a), 27(2) and 27(3), and because of the supremacy of the Constitution of 1996 these rights need to be upheld. All government spheres are charged with creating an environment to meet the constitutional rights of South Africans. A clear expression of these rights is in the preamble to the Constitution of the World Health Organisation as cited by Hassim, Heywood and Berger (2007:133) which states:

*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*

The research seeks to explore the current health care debate and contribute to it. The research includes the historical decision-making of government that has an impact on the current health care environment and reflects the new government's direction. The focus of the research is the National Health Insurance (NHI), which is the unit of analysis or an alternative means of providing for the health care needs of South Africans.

### 1.2 Statement of the problem

The public and private health sectors have huge disparities. On the one hand, the public health sector has 47 million people who, for varying reasons, do not benefit from an effective and efficient functioning health sector. On the other hand, seven million people receive quality health care because they fall in a high income bracket and chose to pay their health care. Inequalities in the health system go well beyond the health sector usage burden, to sector related challenges that prevent access to health service delivery. In this instance, equity is compromised and the provision of health care limited, having implications on access to needed services and equal distribution of health resources, according to Stevens (in Van Rensburg, 2004:16).

Two systems of contributing mechanisms exist that characterise the health care system of South Africa namely, private and tax-based systems. The contributing mechanisms function concurrently and have not been entirely beneficial to the high –, middle – and low – income groups. The risk associated with the cost of falling ill should be insured against in both the public and private sectors. In the private sector, this is frequently not realised where there are many small insurance pools with limited coverage. Cross-subsidisation would be needed to prevent households from becoming impoverished and to protect against financial constraints because of limited coverage. The burden on the public sector as result of the affordability of private health care leads to further financial constraints and the highest attainable standard of health is often not achieved.

### **1.3 Background to the research problem**

The problems government seeks to address are the prevailing historical health care inequities. Before the historical perspective on inequities is provided, it is important to understand what the term equity as well as equality means (as will be mentioned throughout the paper). Reidpath and Allotey (2007:1-2) make a distinction between inequality and inequity. Inequality means that there is an uneven distribution of health in or between populations; they also believe that the entire population can never have the same health status. They are of the opinion that “health inequalities should be of particular interest when those inequalities are attributable to determinants that fall within the capacity of people and societies to moderate”. When the disparities occur, it is not a case of unevenness anymore but unfairness in the distribution of health which turns inequalities into inequities. Health inequities imply that there has been the presence of disparities between advantaged and disadvantaged social groups

Equity according to Ntuli, Kosa and McCoy (1999:1) mean “‘fair shares’ and ‘fair opportunities’ in distribution and access of resources and provision of services”. Equity means that resources should be made available to the most vulnerable people, that opportunity should be created for the improvement of health of the vulnerable groups and not the universal allocation of resources (Ntuli et al. 1999:1). According to Ward (2009:51) equity is conceptually divided into vertical and horizontal equity. On the one hand, vertical equity means that everyone should be treated differently because of their different health care needs (Ward, 2009:51). Mooney (2008:98) expands and state that vertical equity is the “unequal, but equitable, treatment of unequals” and that it is often addressed in funding. Vertical equity requires that public sector resources be allocated to service improvements to the benefit of the poor and vulnerable (McIntyre and

Gilson, 2002:1650). Ensuring the allocation of resources from the wealthy to the poor and vulnerable, Reidpath and Allotey (2007:3) identifies an interesting approximating measure known as the Pietra Ratio or Robin Hood index – the index was so named because of the estimation of wealth that has to be transferred from those with above the mean-level resources to those with less than mean-level resources in order to achieve equality. On the other hand, horizontal equity refers to equal treatment for groups and individuals with the same health care needs (Ward, 2009:51). Mooney (2008:98) terms horizontal equity as the “equal treatment of equals” and in practice it is implemented on the service delivery side.

In order to understand the underlying reasoning behind this situation, it is important to focus on the legislative and social environment that made it conducive for inequities to persist over the years. In 1948 the National Party government promulgated apartheid legislation. Van Rensburg (2004:77) expresses that from then onwards segregation ruled government decision making, especially in the health sector.

When considering the health sector, the National Party government separated those who have higher income from those with little or no income at all. The policy was based on the 1889 established voluntary private health care sector and built on an under-funded public sector which was formally non-profit (McIntyre, Theide, Nkosi, Mutyambizi, Castillo-Tiquelme, Gilson, Erasmus & Goudge, 2007:14). Health care services were provided on work sites by employers to protect their employees. Hassim et al. (2007:166) give account of the commercialisation of the sector after the 1980's and the government's endorsement of privatisation.

The assumption is made that private sector beneficiaries have quality health care because government funding to the health sector was mainly for the advancement of the private sector. The public sector was mainly supported by foreign missionary workers who could not completely address health care needs in rural areas. Neither the Union nor the Apartheid Government had any interest in the indigent peoples of South Africa. Therefore, policies were not formulated to alleviate health care issues in the public domain. Van Rensburg (2004:73) adds that the conditions created were reflected in poor health, with high morbidity and infant maternal mortality rates, including the occurrence of tuberculosis, enteric fever and nutritional deficiencies.

The dire circumstances suffered by those living in the rural areas sparked interventions from interested parties and health care committees to pressurise government to be inclusive in formulating health policy. Anti-segregation proposals tabled by these bodies were not implemented. According to Van Rensburg (2004:77), those proposals that would fit the macro tailor-made government policy were considered and, to a certain extent, implemented.

The focal debate that took place, addressing inequities in health care, revolved around developing a National Health Insurance (NHI) scheme. According to MSN Encarta (2008:1), “National Health Insurance is health insurance that insures a national population for the costs of health care and usually is instituted as a program of healthcare reform”. Further, McIntyre and Van den Heever (2007:73) state that NHI is normally associated with universal cover for the whole population, irrespective of whether they have contributed or not.

In 1883 Germany became the first country to provide NHI. The German Chancellor, Prince Otto von Bismarck, enacted a compulsory sickness-insurance law (MSN Encarta, 2008). Bismarck had a socialist approach to governance. The approach is evident because Germany, through the work of Bismarck, was the first to have a modern social security system. The approach was expressed through compulsory sickness, accident and old-age insurance legislation passed in 1883, 1884 and 1889, respectively (Van Meerhaeghe, 2006:284). Currently, there are approximately 39 countries that provide NHI.

The debate about a NHI scheme in South Africa began more than 70 years ago, according to Shisana (2009a:29). A Committee on NHI (known as the Collie Committee, chaired by Collie), was appointed to investigate the feasibility of NHI in 1936 (Van Rensburg, 2004:74). Although Shisana (2009a:29) indicated that the committee investigated the possibility of NHI in 1941, both Van Rensburg and Shisana agree that the proposal was made to include the whole population, except those in rural areas. Van Rensburg (2004:74) further notes that the committee recommended an expansion of the district surgeon and nurse services in the rural and native areas. Throughout Van Rensburg’s (2004) work on the history of health care in South African it can be assumed that from a historical approach, NHI is still relevant in the health care of the current South African society. Throughout the various timeframes during which the NHI discussion took place; the underlying principle was to create equity in health service provision and to influence policy, thereby creating the environment for change.



The NHI debate re-emerged in 1994 through the National Health Plan, as proposed by the African National Congress (ANC). The move towards attaining equity within the health system implies that government recognises that there has been a consistency of segregation in this area throughout the centuries. This segregation is evident in the historical deprivation of quality health care to the majority of the population who rely on the public health care system while there is a secure provision to the minority 'white population' in the private health care system.

According to McIntyre et al. (2007:77) the Taylor Committee was established in the early part of the 21<sup>st</sup> century and was mandated to investigate an extensive range of social security issues regarding the health sector. In 2002, it ultimately recommended NHI.

In terms of government's commitment to NHI, the Constitution of 1996 has an integral role to play as a guiding instrument for new health care policy. In 1996 the Constitution of the Republic of South Africa was approved by the Constitutional Court and took effect from 1997. The Constitution of 1996 binds the government, in Section 27(2), to take reasonable legislative action in accordance with the available resources and to progressively meet the needs outlined in Section 27(1). In line with government's legislative mandate, great health care needs emanating from the apartheid era, and economic inequality expressed through a high Gini Index, the response should be to regulate through policy (McIntyre et al., 2007:10). The Gini Index is a measure of income inequality within a country ranging from zero to 100 – the closer to zero the index is, the more equitable income distribution is across different income groups; the closer to 100 it is, the more inequitable the distribution of income (McIntyre et al., 2007:10). Policy regulations in the health sector are mostly aimed at the private sector because of historic advancement and escalating costs of private care despite consistent high profits in the sector (Leon & Mabope, 2005). According to Leon and Mabope (2005), the state practised its regulating function through the Medical Schemes Act (1998), Medicines and Related Substances Control Amendment Act (2002), and the National Health Act (2003) in order to realise government's policy objectives. Tshabalala-Msimang (2008) states that, "some legislation to support the initiation of the implementation of NHI has to some extent already been developed and implemented. These include but are not limited to the Medical Schemes Act and its subsequent amendments, the National Health Act, and the Single Exit Price Regulations."

A task team was established by the ANC in June 2009, as a result of President Jacob Zuma's State of the Nation Address. Khanyile (2009:9) state that the team was required to investigate

the broadening of public-private partnerships and to find “cost-effective solutions of providing and managing health services”.

#### **1.4 Preliminary literature review**

The background to NHI serves the purpose of widening the contextual framework, but Van Rensburg (2004) explains that this history has caused inherent problems in the current South African health care sector.

##### **1.4.1 Background to the health sector problem**

Firstly, McIntyre and Van den Heever (2007) identify cream skimming and cost-spiralling as problems in the private health sector. On one hand, according to these authors, cream skimming occurs mainly because the voluntary private health insurance sector (medical schemes) wants to increase profits by creating benefit packages that deliberately exclude those that have a high risk of falling ill. On the other hand, the cost-spiral results from the apparent inability to extend medical cover to the rest of the population because of the cost of health insurance.

Factors that drove the cost spiral in the 1980s and 1990s were medicines and private hospitals. In recent years, however, the cost drivers became private hospitals, specialists and non-health activities such as administration, managed care and broker activities. Ncayiyana (2008:229) views cost-spiral as a big obstacle because medical schemes operate in a weak regulatory context. This context mirrors two important aspects: the cost increase which results in an increased cost burden and causes an increase in health care costs above inflation (Leon & Mabope, 2005), and an evident decline in benefits (Ncayiyana, 2004:229).

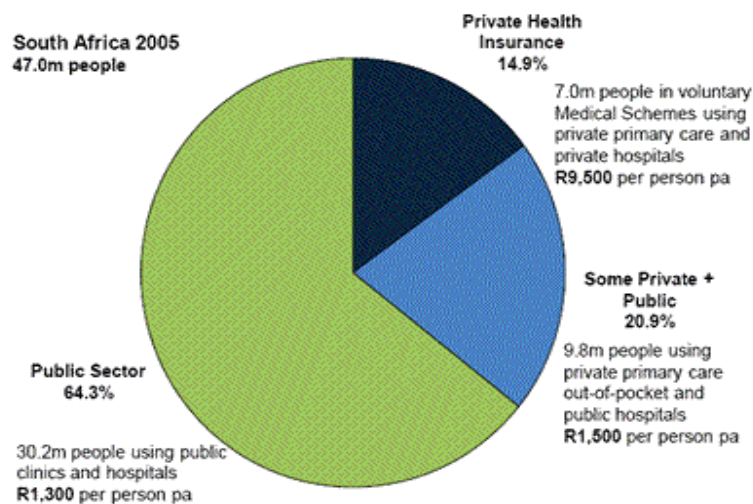
Secondly, financial injection by the state into the public health sector is very small compared to the increasing needs of the poorer population. Tshabalala-Msimang (Kahn, 2008) indicates that government funding has flat-lined, with R1000 per capita spent over the past 10 years. Furthermore, 36% of the national health expenditure is allocated to servicing the needs of 68% of the poorer population. Budgetary allocations to the public sector do not keep up with population changes and changes in morbidity rates; this means that the sector is under-funded.

In direct contrast to the bleak reality in the public sector, Kahn (2008) notes that private health care spending experienced an increase of 50%, from about R4 000 per capita in 1998 to R6 000 per capita in 2005. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009:852) state that another problem in the private sector is the quality of clinical care because there is no oversight of the quality of care provided in this sector.

Lastly, Matlala (2008:26-27) brings to the fore a unique point of view as to what the inherent problem is. Poverty, which is ultimately a result of unemployment, is thought to be the reason private health care is unaffordable. Matlala (2008:27) believes that compared to Canada and the USA, the South African private health sector is affordable at \$300 per annum.

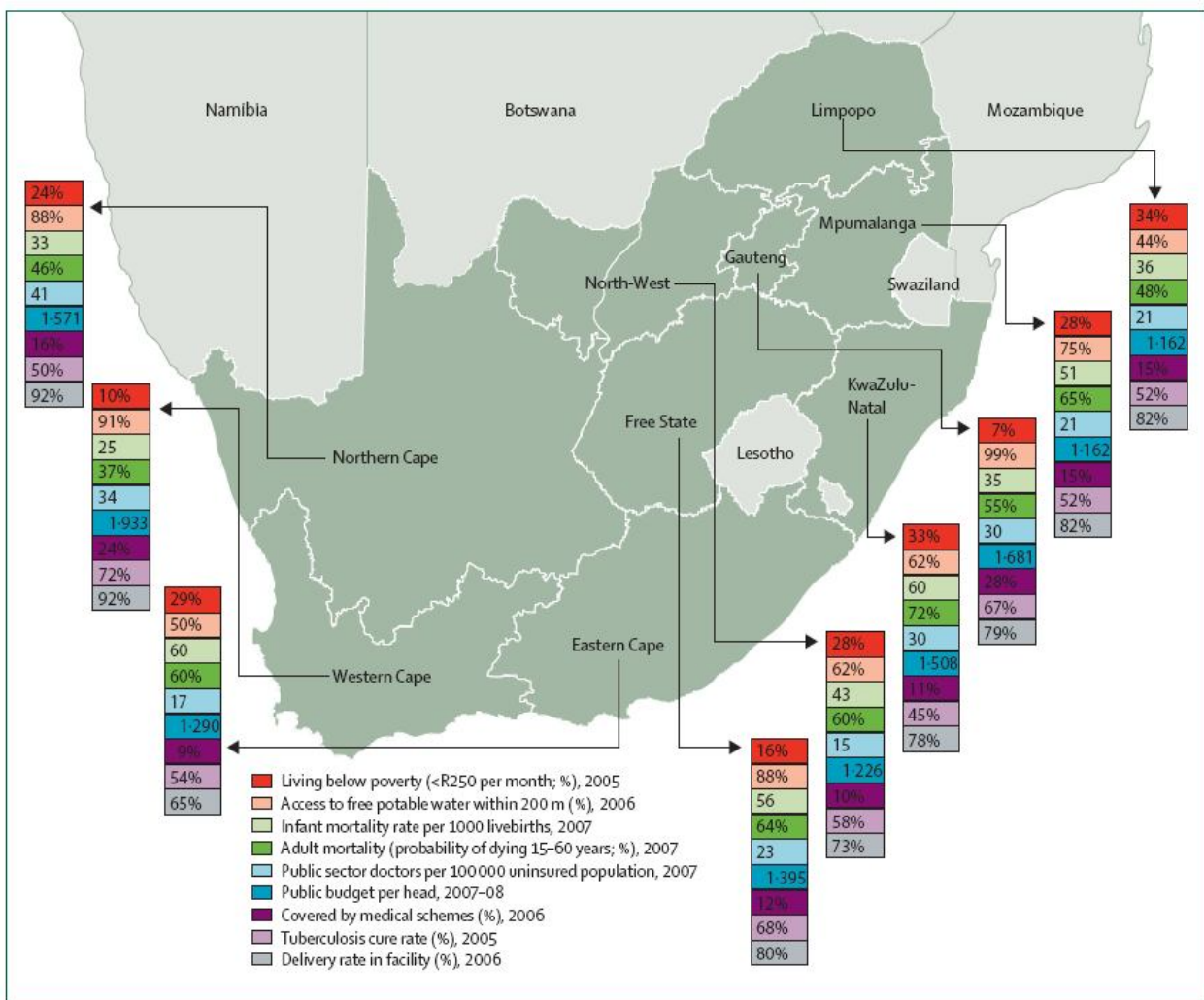
The reality brought across is that indigent people are suffering because of unemployment. The figures depict this reality: 9, 6 million people do not have medical cover, those insured constitute 7, 4 million of the population, the remainder are the poorest of the poor. Matlala advocates the creation of employment and suggests that government should develop a robust poverty alleviation programme.

The commercialisation of the health sector by the apartheid government left a legacy of inequities that are still evident in South Africa today. The public sector has many more users than the private sector and health care consumption remains skewed as depicted in Figure 1.1.



**Figure 1.1:** Distribution of various groups using different means of services  
 Source: ANC Today. 2009. A unified, equitable, and integrated national health system that benefits all South Africans (online)

Considering issues from the cost-spiral in the private sector to the need for financial resources in the public sector, it is quite clear that government's remedial action should address a spectrum of issues. Deduced from a broader perspective as shown in Figure 1.2, it is evident that intervention is required for both the wealthy and the poor of South Africa. Government has proposed a mandatory universal insurance scheme (also known as NHI) to address the huge disparities between private and public health care service provision, to fulfil statutory obligations.



**Figure 1.2:** Indicators for health and development in South Africa's provinces, 2008  
Source: Coovadia, Jewkes, Barron, Sanders and McIntyre (2009:825)

The obligations outlined in the Constitution of South Africa 1996 stipulate in section 27 are that everyone has the right to access to health care services. This right should be established on the

values of human dignity and equality (Section 1 (a)), not just the accomplishment of minimal health care intervention. The Constitution of 1996 further outlines in section 27 (2), the extent to which government must meet its statutory obligations: “the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights”. The government is mandated to fulfil all the obligations imposed by the Constitution; any law or conduct inconsistent with it is invalid according to section 2. Deduced from government’s statutory obligations to the citizens, decision-making should be relevant to the changing needs of the mass. Therefore, the problems in the health sector that government wants to address with the NHI model must incorporate access, equity and the progressive realisation of the health care needs of the people.

#### **1.4.2 The health sector solution**

Tshabalala-Msimang discussed various possibilities considered for the implementation of NHI at a colloquium held in Cape Town. Tshabalala-Msimang stated that: “government is committed to an NHI system which would comprise three elements”, namely:

- government-mandated health insurance covers for specific groups;
- income cross-subsidies among contributors; and
- risk-related cross-subsidies among contributors (Botha & Hendricks, 2008:10).

In a nutshell, the proposed NHI scheme includes the following proposals (Anon, 2009:2):

- A National Health Insurance Authority (NHIA) will be established, run by a Chief Executive Officer (CEO) who will directly report to the minister of health. The minister will ultimately be accountable to parliament for the performance of the NHIA.
- The authority will act as the administrator of the NHI Fund and will be structured as a single purchaser of health services from both the private and public sector with sub-national offices at provincial and district levels.
- The NHI fund will pool funds generated from an earmarked health tax estimated at around 5% of taxpayers’ income and general tax. In addition, 85% of medical scheme members’ contributions will be diverted to the NHI fund.
- The poor, low-income earners and pensioners will be exempted from paying contributions.
- The benefit package will include comprehensive out - and in-patient care at public and private facilities.
- Medical schemes will only be able to cover benefits not covered by the NHI.

- Tax deductibility of medical schemes will be removed.
- All General Practitioners (GPs) will have to move into accredited group practices and contract with government to deliver primary health services on a capitation basis.
- Everybody in South Africa (SA) will have to register for NHI and enrol with a primary healthcare provider they can choose from a list of accredited practitioners in either the private or public sector in their area. The aim is to have all South Africans enrolled as beneficiaries of NHI before 2014.
- GPs will act as gatekeepers and the NHIA will only authorise visits to hospitals and specialists after referral by a general practitioner.
- Payments to private specialists, public doctors and hospitals will be case-based. The budgets will, nonetheless, be calculated on a risk-adjusted capitation formula. Only in exceptional circumstances will out-of-pocket payments be used.
- Payment mechanisms will be linked to quality improvements and cost containment. There may be an element of better payment for increased performance.
- The shortage of doctors will be addressed by importing Cuban doctors, lifting restrictions that do not allow foreign doctors to practice in SA, importing specialist skills and attracting back South African doctors currently working abroad.
- A detailed audit of both private and public facilities in the country will be done to establish capacity and distribution. With the help of NHI financing, facilities in the public sector will be improved and expanded.

The intentional use of *will* in this proposal has brought about uncertainty as to government's real plans to implement NHI. Findings conclude that democracy and policy making form the crux of the discussion. This leaves room to briefly shed light on other relevant issues that need to be investigated. The process of policy formulation in a democracy is important because people's needs are heard through the voice of the elected representatives, and governance is expressed in terms of how remedial policy action governs certain sectors of the country.

According to Kolar (2005:1) democracy means "... that all the people should be able to have their say in one way or another in everything that affects their lives". Therefore, caution is required when undertaking issues of national interest, especially health care. Kolar explains that, ideally, representative democracy involves representatives consulting all constituencies when making decisions. This true form of representative democracy seldom exists because elected representatives do not necessarily consult their constituencies and can easily evolve

into elected dictators. Kolar could come to this conclusion because, according to the Oxford Advanced Learner's Dictionary (2006:312), 'constituency' is defined as, "... a particular group of people in society who are likely to support a person, an idea or a product". From the intentional use of language in this proposal, as decided by the ANC task team, one can identify distinct aspects of representative democracy.

On the premise of defining democracy, it is assumed that democracy is expressed through policy or policy-making. According to Barbier (as quoted in course notes, 2008:1) public policy is, "...whatever government chooses to do or not to do...and it is a statement of intention to reach a specific objective...". Based on Barbier's definition, the policy-making process can be analysed, to find out how the task team arrived at the point of expressing what government chooses to do or not to do, and how the team expected it to be made mandatory. The process based on the systems model (see appendix) is reflected in phase three, processing the issues which involves the identification of problems and major stakeholders' needs (Fox & Bayat, 2006:53). Because the public, according to Hendrickse (2006:40), is represented by interest and pressure groups, they can exert pressure on government. When a policy issue is identified that has a potentially wide ranging effect on society in general, the public may mobilise support to influence policy makers, so that any changes in policy favour the electorate. Identifying the problems in health care provision together with the stakeholders, and then deciding the course of action should have been done but was not. Waters (2009) concurs when he states that if it had not been for the leaked documents, on 16 February 2009, policy developments would not have been made public.

#### **1.4.3 National health insurance since 1994**

Evidence of government's will to change the policy focus to universal health care is clearly noted from 1994 onwards. Since 1994 the ANC-led government has made various attempts to implement NHI to address inequities prevailing in the health sector. The Department of Health (DoH) proposed the implementation of a NHI scheme which included universal coverage, contracting general practitioners paid through capitation, and limiting the use of additional insurance (Shisana, 2009b:1). The proposal was not accepted because of its inflexibility even though it met the constitutional mandate of access to health care for all and costs were contained (Shisana, 2009b:1). Government set up a committee of inquiry into NHI; in 1995 the report was presented and was based on the earlier proposal of the DoH (Shisana, 2009b:1).

The committee recommended social health insurance (SHI), universal access to primary health care and regulation of the private medical schemes (Shisana, 2009b:1). The component of universal primary health care was implemented in 1996 as well as partial regulation of medical schemes (Shisana, 2009b:1).

In 1997, the DoH used the SHI proposal as a basis for a new committee of inquiry into social security. Under this plan, the SHI system would support the public health system, there would be mandatory cover for those who earned above a tax threshold and all employed people and their dependants would have public hospital health cover (Shisana, 2009b:1). However, there were problems in that the plan did not cover the entire population, did not raise required funds to improve health services and inadequately linked primary health cover with hospital cover (Shisana, 2009b:1). According to McIntyre et al. (2007:77), and as mentioned earlier, the Taylor Committee was established in the early part of the 21<sup>st</sup> century and in 2002 recommended NHI implementation. Following the recommendation in 2002, Khanyile (2009:9) notes that in 2009 the ANC called a task team to find solutions for providing and managing cost-effective health services and expanding public-private partnerships.

The NHI is one health care model, there are three others, namely: Beveridge, Bismarck and the Out-of-pocket models. The models differ primarily in the extent of state involvement. Under the Beveridge model the state is the sole payer and provides hospitals, clinics, and doctors to all citizens. The Bismarck model is largely run by private hospitals, doctors and insurance plans. The insurance companies work on a non-profit basis and under strict legislative regulations. In the NHI model, government's role is a combination of the Beveridge and Bismarck models. Government runs a national insurance programme, tax is collected into the insurance fund and private providers are used and paid by the fund. Health care in the Out-of-pocket model requires people to pay for health services out of their pocket (Hamilton, 2008).

#### **1.4.4 The current national health insurance debate**

According to Gilson (2009:22), the debate has largely been taking place 'behind closed doors'. In a MoneyWeb Radio (2009) interview, Van den Heever remarked on government's lack of public inclusivity regarding the formulation of the NHI scheme and speculated that government might release the document and provide three months for public participation. This, in fact, implies the speedy formulation of the necessary policies and NHI implementation. Gilson's statement highlights the need for the discussion about policy at a more inclusive level, with



public participation in the NHI proposals not to be regarded as optional because the lives of all South Africans will be influenced.

The debate amongst experts is noteworthy, as different arguments and possibilities for South Africa's health sector are emphasised. The NHI scheme has caused a heated debate which is developing into a gauge by which people measure the success of implementing it, while others measure the quality of the services it will provide. Several contributions have been made to this discourse.

Dr Olive Shisana, head of the Human Sciences Research Council, sketches the contextual thinking behind the speedy implementation of the NHI system. Shisana (2009a:29) refers to the historical situation brought about because of inequity in health care provision. She firmly believes in implementing the NHI as it will address the historical inequity very well, especially that which existed in the care of indigent people.

Sidley (2009) raises concerns about the small tax base, including the pressure of economic downturn which will cause increasing difficulties to finance a NHI. In contrast, Davie (2008) emphasises the potential controversy around the quality and quantity of health care delivery, and about ensuring government's official role as health care provider. More recently, Davie (2009) suggests that there will be no flexibility in the selection of preferred services.

In line with the views expressed by Shisana, Sidley and Davie, Kruger (2007) is concerned with what the benefit package will include and refers to the situations that exist in other countries. For example, people who smoke and are obese are refused treatment until they lose weight or stop smoking. Furthermore, costs related to creating incentives for medical professionals to stay in the country are also a concern, according to Kruger.

### **1.5 Research questions**

The questions listed provide guidance on the important aspects to be covered in this research:

- What are the challenges in the public and private health sectors pertaining to equity and access?
- Will the proposed NHI system address the four criteria in the final analysis in the public and private sectors, and ensure equity in health care service delivery?

- What other health care models could be implemented?

## **1.6 Objectives of the research**

The following are the objectives of this research:

- To determine the challenges of the current health system.
- To determine and present the most suitable health model options based on the criteria.
- To analyse critical information about the proposed NHI scheme in terms of financing.

## **1.7 Research design and methodology**

The current proposed reform to South Africa's health system is through a NHI system. A lens comparative analysis of four health care models including the NHI will be undertaken to ascertain as to which is the most suitable model for South Africa's unique health care situation. Lens comparisons are made when phenomena are viewed from the perspective of another similar phenomenon (Walk, 1998). Thus all four health care models will be analysed through the lens of, and by comparison with the current health care challenges facing South Africa. The document review will include an analysis of the contributing mechanisms, in the public and private sectors. A finance criterion will be utilised consisting of four components – equity, efficiency, sustainability and feasibility – against which the suitability of all four models will be tested. The criteria, as proposed by McIntyre (2007), are selected on the basis of their relevance and compliance to the international criteria in terms of contributing mechanisms in developing countries.

A document study is the third, and often neglected method that can be used in qualitative research; observations and interviewing are normally used to collect data (De Vos, Strydom, Fouche & Delport, 2005:314). The literature sources will be a combination of official documents, mass media and archival material (De Vos et al., 2005:314). De Vos et al. (2005:345) state that when documents, such as personal, non-personal and group documents aimed at mass media are studied for scientific research purposes, then the method of document study, as a data collection method becomes operative. Document study provides the researcher the flexibility of being able draw data from both primary and secondary sources. To aid in the analysis of secondary sources, Nieuwenhuis (2007:71) explains that it is best to use conceptual study.

According to Nieuwenhuis (2007:71), conceptual study is largely based on the in-depth critical analysis of secondary sources that is interpreted and derived from a primary source.

The advantages of a document study, according to De Vos et al. (2005:318) are as follows:

- Relatively low cost – the only cost involved when conducting a document study is related to dispersion, availability and travel distance covered in order to obtain documents. A document study is relatively more affordable than conducting a comprehensive survey.
- Confession – a document study allows the researcher to analyse diarised confessions of a person after death. Using the document study approach is the only way to review suicide notes, diaries and posthumously published autobiographies.
- Non-reactivity – the content of the document is not affected by the activity of the researcher because the documents cannot anticipate their analysis.
- Inaccessible subjects – when conducting the study of documents there is no need for personal contact with the respondents. The researcher is able to study information about civilisations long ago as well as their behaviour.

The advantages applicable to this study are relatively low cost, non-reactivity and inaccessible subjects.

## **1.8 Data analysis**

The approach that will be used to analyse data in this research is content analysis. Maree (2007:101) states that content analysis is "... a systematic approach to qualitative data analysis that identifies and summarises message content". This method is used to analyse things such as books, brochures, written documents, transcripts, news reports and visual media (Nieuwenhuis, 2007:101). The sources analysed for the purpose of this study will include documents, books, journals and news reports.

## **1.9 Delineation of the research**

The scope of this research will be limited to relevant documents, including primary and secondary sources that will assist in shedding light on the main policy issues concerned with

analysing the suitability of NHI as well as considering other health care options. The review will include legislation, media releases, journal articles and all other relevant sources of information.

### **1.10 Significance of the research**

The research is based on the need for speedy intervention by government in the health sector. Holistically, there are many aspects to be considered when intervening, but democracy and policy making have a major role. The research will present different perspectives around the discourse regarding government's response to the needs of the health sector. It will also analyse the crucial challenges that existed in the current health system. The significance of the research is that it looks at the possible functioning of each of the four different contributing mechanisms (NHI, Bismarck, Beveridge and Out-of-pocket models) and the implications of each mechanism if it were implemented in South Africa.

### **1.11 Expected outcomes, results and contributions of the research**

The research is expected to include all critical aspects of the health system of South Africa, and to forecast the suitability of not only NHI but also the other contributing mechanisms. The likely results of implementing various contributing mechanisms are to provide more insight for policy decision makers. Furthermore, it is anticipated that lessons from other countries will serve as a guide to address South Africa's unique health sector problems.

### **1.12 Summary**

From the discourse on NHI, it is clear that intervention is necessary because of historical injustices which have translated into inequitable services in the public and private health sectors. The proposed NHI does not only focus on the majority of the population who cannot afford private health care, but also on those who cannot afford increases in the private sector.

Although the premise of the NHI is built on ensuring that the whole population benefit, other options for South Africa should also be weighed and analysed to match the heterogeneous needs of such a unique country.

### **1.13 Keywords**

National Health Insurance (NHI)

Health care  
Public health sector  
Private health sector

## **CHAPTER TWO**

### **THE SOUTH AFRICAN HEALTH SYSTEM**

#### **2.1 Introduction**

The South African government has made progress in addressing the health care inequalities that caused the exclusion of black, coloured and Indian people from the well-funded private sector. Even though government has made great strides in providing access to services, 30.2 million people are still not absorbed into an equitable health system. Many inequalities persist in spite of major policy shifts. A minority of the population receive private care because they can afford it and a large chunk of the national health budget is still allocated to this sector. This chapter provides an overview of the public and private health sectors, developments before apartheid as well as a brief overview after apartheid and the scope of the health sector problems. Included in this chapter is the analysis of the relevant legislation, an overview of the hierarchical structure of the national health system as well as a survey of health system financing.

#### **2.2 Background to the health sector**

The health sector history of South Africa is abounding with the influences of segregation and apartheid notions and legislation. Since the establishment of hospitals in the time of Jan van Riebeeck in 1652 until the restructuring of health care in the early 1990s, the health system was structured according to legislation promulgated by the colonial government rule which automatically provided them with elevated power in the South African society. Despite these facts, the health system has undergone many developments over the years of different party rule in South Africa. The next section gives more insight about the background and developments in legislation.

##### **2.2.1 Historical overview of the public health sector**

In response to the measles and smallpox outbreak, the Contagious Disease Act No. 1 of 1856 was enacted and promulgated in 1868. In 1874, the Medical Tax Act was passed. The workers of the time opposed the Act; consequently, the Act was enforced in 1882 based on the employers' levy payment to the Cape government (Department of Health, 2002:7).

1883 was the year when the first Public Management Act (Act 4 of 1883) was promulgated in Kimberley that pertained to the health system. The Act was a policy response to the smallpox epidemic and the governor was authorised to give emergency powers to the local authorities during an epidemic (Van Rensburg, 2004:57). For the first time vaccines and notification of infectious diseases was made compulsory in the Cape Colony (Department, 2002:7). The local authorities assumed emergency powers, permitting officials to enter premises and to draw up and enforce quarantine regulations. Local authorities, according to the Public Management Act, had control over the establishment of hospitals and clinics, while government paid 50% of the cost of expenses and maintenance (Department of Health, 2002:7).

A national convention set the platform for the South African Act of 1909, which established the union of four colonies (Cape of Good Hope, Natal, Transvaal and Orange River Colony). The Act made incomplete reference to health care (Department of Health, 2002:7). Thus the local authorities had the responsibility of developing measures to deal with outbreaks of infectious disease and environmental hygiene, and provincial councils inherited local colonial laws. The 1919 influenza epidemic exposed the overlapping responsibilities, procedures, safeguards and confusion that the inherited colonial system brought about (Department of Health, 2002:7-8). The Public Health Act (Act 36 of 1919) was enacted to address these issues. Under the Public Health Act, the Department of Health (DoH) had executive powers and authorities to advise, assist, and, if necessary, pressurise local and provincial administrations to fulfil their public responsibilities (Department of Health, 2002:8). According to Van Rensburg (2004:72) the Act firstly established uniform preventive health services at a national level and secondly, establish an additional national department to coordinate the health services of local authorities. The provincial administrations continued to have the responsibilities of administering local government, the maintenance, and management of general hospitals and matters relating to charitable institutions and pauper medical relief (Department, 2002:8).

The gold and mining industries were obligated to provide hygienic housing, an adequate diet, and hospitals for native labourers under the Native Regulation Act of 1911 (Department of Health, 2002:8). Employers did not have a tax burden, but had to provide hospitals in accordance with regulations and specifications in the legislation. Hospitals in the rural areas were established by missionaries with no financial contribution from local authorities.

In 1946 the Public Health Act was amended to demarcate the responsibilities of national and provincial government (Department of Health, 2002:9). Funding was made available to provincial and local governments for general and private out-patient services. Consequently, difficulties in funding arose. The influence of political rather than health criteria formed the crux of policy making in 1948 (Department of Health, 2002:8). The objective was to prioritise the health care needs of the white population above the other population groups. Health care needs of the black, coloured and Indian members of society were not considered important at the time. This situation was perpetuated by the proposal in the Tomlinson Report of 1954, to have separate 'Bantu Health Services'(Department of Health, 2002:9) . The report recommended that the DoH discontinue initiatives for the development of a unitary health system. Health policy and service delivery was further fragmented because numerous first tier government departments were extended.

In 1977, under the Health Act, the DoH was assigned the role of coordinating health services of provincial and local authorities as well as providing additional services, if necessary (Department of Health, 2002:9). Despite the policy intention, fragmentation amongst the three tiers of authority and services still existed. For this reason, the Health Matters Advisory Committee and the National Health Policy Council was formed in 1977 and, in terms of coordinating the numerous health departments, the Regional Health Organisation was established in 1979 (Department of Health, 2002:9).

The increasing degree of fragmentation in the 1980s was characterised by the separation of public facilities for whites and blacks (McIntyre et al., 2007:11), the skewed resource allocation and the formation of 17 different political entities (Department of Health, 2002:10). The Browne Commission, in 1986, advised, what is now considered to be, excessive control over health services. This produced misallocation of resources, duplication of services and poor communication between various tiers. The period 1980 – 1990 featured (Department of Health, 2002:10):

- A dual health system based on income.
- Public sector barriers. The public sector barrier structure had many informal barriers such as geographical access and the appropriateness of services.
- Segregation of public hospitals which resulted in the growth of the private sector.
- Growth in public hospital utilisation which resulted in drastic increases in medical costs.



## **2.2.2 Historical overview of the private sector**

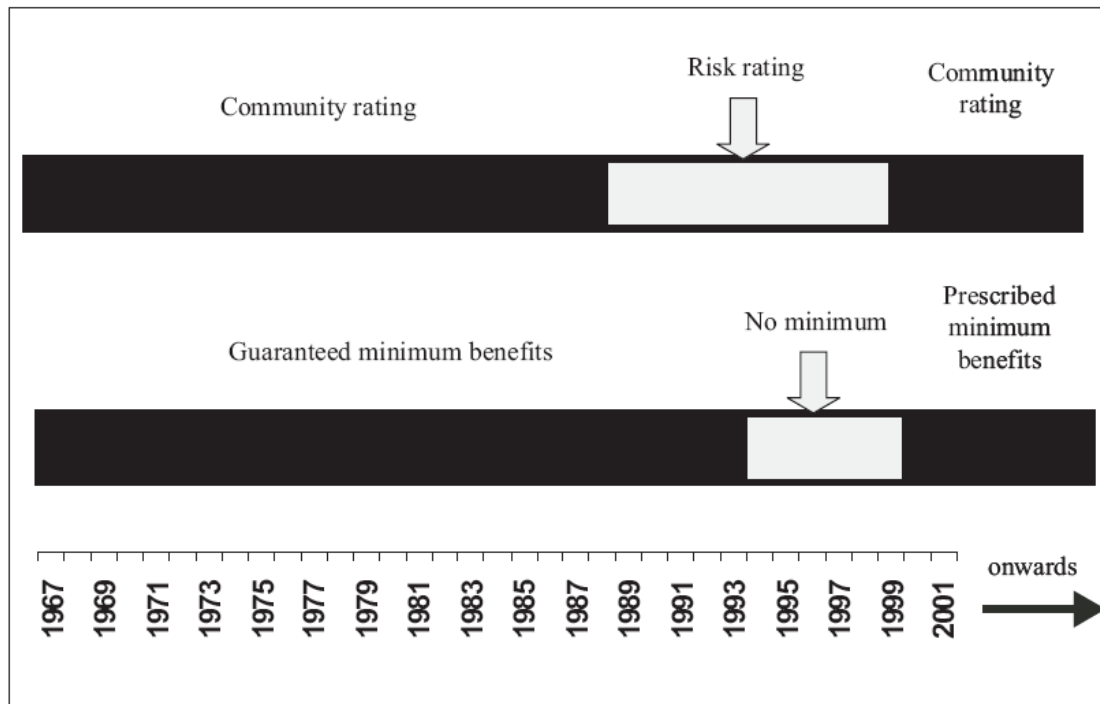
De Beers Consolidated Mines Ltd Benefit Society was the first medical scheme in 1889. According to Coovadia et al. (2009:10) medical schemes were established for the needs of the white mine workers until the late 1970's and was expanded from then onwards. Seven such schemes were in existence by 1910, in 1940, 48 medical schemes existed and by 1960 there were 169 medical schemes (Kruger, n.d.). Medical scheme coverage also grew exponentially over the 1945 – 1960 period, from 48% to 80%.

The Medical Schemes Act (Act 72 of 1967) was founded on solidarity principles; it contained minimum benefits and required community-rating (Kruger, n.d.). More flexibility and less regulation in 1980 was the consequence of an inadequate spread of risk-pressure. In 1986 the Browne Commission reported the development of a free-market theme and the provisioning of a gradual privatisation of the public health services (Kruger, n.d.). Coovadia et al. (2009:10) state that this can be ascribed to the “explicit government policy of privatisation” that was encouraged by international trends towards an increased role for the private sector.

The Browne Commission resolved that risk-rating and experience-rating should take place in medical schemes (Kruger, n.d.). This approach would provide for greater flexibility in terms of the rate determination of contributions. Meaning that different contribution rates for different classes of risk would be employed, providing the opportunity for the selection of different benefits chosen by groups and individuals based on the satisfaction and needs. The recommendations set the platform for mutuality principles for the next 11 years, a drift from solidarity. The mutuality principle is evident when an applicant makes a contribution to a pooled fund that is in accordance with their risk at time of application as well as at time when a loss is experienced (McLeod, 2005:136). Solidarity differs from mutuality on the premise that contributions are made in accordance with an applicant's ability to pay and is also the basis for social security, social insurance and national insurance (McLeod, 2005:136).

Medical schemes were able to “exclude or limit cover for procedures, and risk-rate to a greater extent”, but had to be balanced to directly supply health care by owning clinics or hospitals and employing medical professionals (Kruger, n.d.). According to Kruger, in the 1990s older and sicker members were excluded from cover to a greater extent. By mid-90s, no open scheme permitted anyone older than 55 to join as an individual member. Virtually all open schemes applied life-time exclusions for pre-existing conditions. By 1999 the majority of medical scheme

membership was in an environment which excluded vulnerable groups from cover, but medical scheme cover continued to rise as depicted in Figure 2.1.

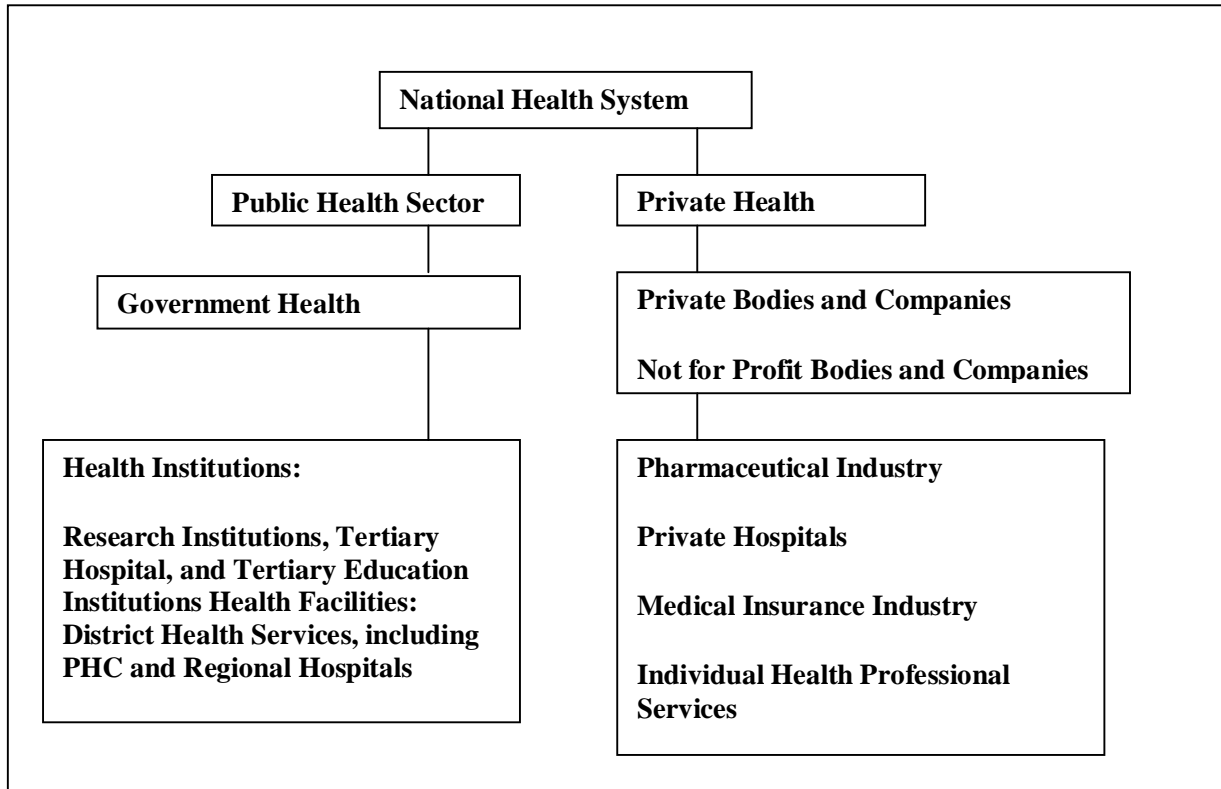


**Figure 2.1:** History of legislation relating to medical schemes  
Source: McLeod. 2005. Mutuality and solidarity in health care in South Africa

### 2.3 The national health system as promulgated by the NHA

One of government's first, most comprehensive sectoral plans, according to Chetty (2007:3-4), is the African National Congress (ANC) National Health Plan of 1994. This plan embodies the new government's principles of social justice and equity. As stipulated in the National Health Plan, a single structure responsible for all public and private health care delivery and all departments should be integrated (see Figure 2.2 for a macro perspective of the health sector) resultantly, the 14 bantustan administrations were consolidated into nine provincial health departments (Coovadia et al., 2009:828). The overall health care responsibility moved to the National Health Minister supported by the DoH (Department of Health, 2002:11). Health sector goals were incorporated into the Reconstruction and Development Plan (RDP) which became

the guiding policy document. The National Health Act (NHA) (61 of 2003) provides details of the current health system. Heywood et al. (2007:100) are of the opinion that “the NHA set the legislative framework of health care in the country”.



**Figure 2.2:** Macro organisation of the current South African Health System

Source: PSI HIV/AIDS Southern Africa Project Report: The health sector in South Africa

The components of the National Health System of South Africa are delineated in the NHA. The NHA addresses inequalities by imposing regulations within which the three spheres must operate and enforcing the functioning of a health system. The aims of the NHA, as provided in the preamble to the National Health Act (Act 61 of 2003), are:

- to unite the various elements of the national health system in a common goal to actively promote and improve the national health system;

- to provide for a system of cooperative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and the delivery of quality health care services;
- to establish a system based on decentralised management principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of equity and advocacy which encourages participation; and
- to promote a spirit of cooperation and shared responsibility among public and private professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

There are three components in the National Health System, as described by Heywood et al. (2007:101-103), namely, free health care services, the rights of users and duties of providers.

### **2.3.1 Three health system levels**

The NHA gives effect to the national health system that is divided into three levels. Each level is responsible for a different function of the health system, as expressed in chapters three, four and five of the Act. At the national level the NHA's function is to identify national goals, priorities, norms and standards for health service provision. The Minister of Health has the overall responsibility for overseeing these duties. At the provincial level the NHA has a care-taker role. It looks after the public and private hospitals, and those hospitals providing specialised health care, ensuring that there are systems in place to maintain quality control, and to support districts in providing health services. According to the NHA, the head of health within a province must consult with communities about health matters (s24(q) of NHA). The nine provincial executive councils are responsible for implementing these responsibilities.

At the final level it is the district health structures that are central to the delivery of primary health care which forms the core of the health services. The districts are determined by the metropolitan municipal boundaries. Provincial governments are allowed to assist health care delivery in the districts by setting up health sub-districts. All districts have to provide municipal health services as well as water and sanitation services.

### **2.3.2 Free health care services**

Based on the former President Nelson Mandela's free health care policy declaration in 1995, the NHA makes provision for free health care to all pregnant women and children under the age of six who are not beneficiaries of a medical scheme (s4(3) of NHA). The Act also entitles every person in South Africa to primary health care if he or she is not a member of a medical scheme. The Minister of Health must prescribe the provision of essential services to all residing in South Africa.

### **2.3.3 Rights of users and duties of providers**

The health care rights of users that are recognised in the NHA, is an important aspect, and every user must:

- “be given information about their health and treatment options, as well as their right to refuse treatment;
- provide informed consent for treatment or care by a health service provider and participate in decisions about their care;
- be provided with a written report when they are discharged from a health establishment and have access to their own personal information;
- have their medical records kept confidential; and
- have their complaints investigated” (Heywood et al., 2007:102-103).

The health authorities' duties are to disseminate information about the types and availability of health services, to organise health services, and to operate schedules and timetables for visits (s12 of the NHA). The rights of users and health providers are equally important. Patients are to treat health workers with respect and dignity; if a health worker is abused or sexually harassed by a patient, the health worker can refuse to treat the patient.

### **2.3.4 Establishing advisory and consultative bodies**

To enhance a notion of enquiry and advocacy, Ministers and MECs are required to launch a number of bodies at each sphere of government as outlined in chapters one, two and three of

the NHA. The functions of these bodies include policy-making, expert guidance and monitoring of health services. The representative bodies are:

- The National Health Council (NHC) – The council is solely made up of members appointed by government. The council's primary function is to advise the Minister on policy issues and consult with or receive representation from civil society.
- National Health Consultative Forum (NHCF) – All relevant stakeholders are included in this forum. The forum is responsible for information sharing on an annual basis.
- Provincial Health Councils (PHC) – There must be a council in every province composed of government appointees. The forum has a purely advisory role and may consult with and receive representation from civil society like the NHC.
- Provincial Health Consultative Forums (PHCF) – Once these forums have been established they will be required to report to the PHC on an annual basis.
- District Health Councils (DHC) – Provincial legislators still need to pass legislation giving effect to the establishment and functioning of DHCs.

There are no district consultative councils, but the Minister and provincial governments are required to establish representative health boards and clinic committees. The committees and boards must “include representatives from the communities served by the clinics of the hospital” (Heywood et al., 2007:103). At a local level, communities and other civil society structures can play an important role when engaging in a formal manner with those responsible for service delivery. The involvement of the community is central to the promotion of access to health services. Communities and other interested parties have a great opportunity to ensure monitoring and evaluation in terms of health services rendered by the authorities in accordance with their obligations.

In addition to the other bodies, the NHA is expected to establish:

- The Forum of Statutory Health Professional Councils composed of representatives of each professional council, officials from the DoH and community representatives.
- The National Health Research Committee that is tasked with identifying and co-ordinating health priorities.

- The National Health Research Ethics Council that has the responsibility of setting norms and standards for health research.

### **2.3.5 Establishing monitoring bodies**

The establishment of monitoring bodies refers to institutions overseeing and monitoring health facilities, thus closing the gap between complaints against individuals and the institution. For example, the Health Professions Council of South Africa is a body that focuses on the good practice of health professionals, but such a body does not cater for the monitoring of the whole institution. Therefore, the NHA monitoring body address the current policy gap by ensuring that:

- The provincial health department establishes an Inspectorate of Health Compliance that must submit a quarterly report to the Health MEC.
- A National Inspectorate of Health Compliance and an ombudsperson are appointed to monitor public and private health facilities and inspect each health establishment every three years.
- Monitoring and enforcement of compliance with the Act is done by Health Officers who are appointed by the Minister, MEC's or mayors to carry out inspections and request needed documents. Obstruction or denial of information provided by the Health Officers is a criminal offence.

## **2.4 National health system financing**

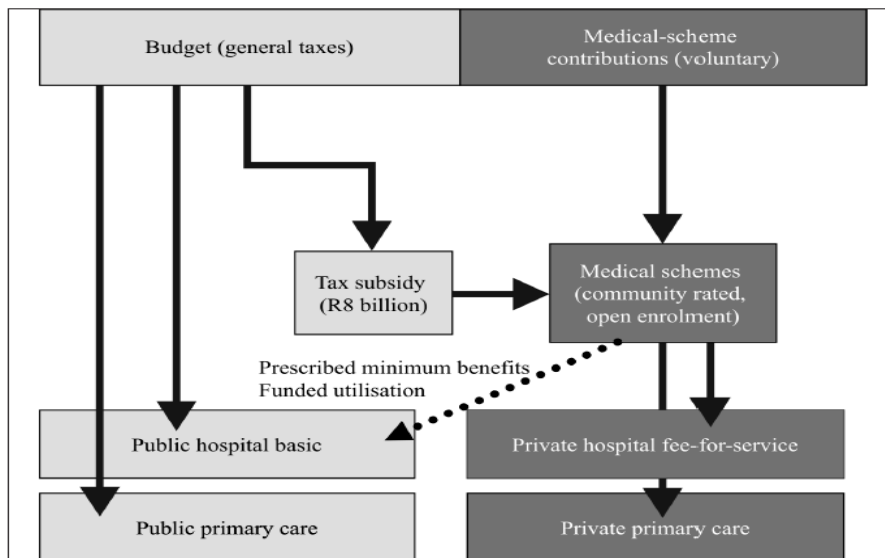
Before the division of revenue between the three levels, government sets aside a contingency reserve and allocates it midway through the year (Heywood et al., 2007:77). These funds are used to cushion changes in the economy and meet unforeseen spending needs. The remaining funds, the non-interest expenditure or total revenue available to be shared, are vertically divided between national and provincial spheres and horizontally between provincial and local spheres (as indicated in Figure 2.3).

Top slice:						
Interest payments for debt, contingency reserves, skills development grant/levy scheme						
Provincial Equitable Share:						
Divided horizontally between the provinces by formula						
Local Government Equitable Share						
Divided horizontally by formula						

**Figure 2.3:** Division of all revenue raised nationally

Source: Heywood et al. (2007:77)

Government also allocates a subsidy to the private sector (see Figure 2.4, McLeod, 2005:140).



**Figure 2.4:** The South African health care system in 2000

Source: McLeod. 2005. Mutuality and solidarity in health care in South Africa

In this vertical division national government retains 36%, provincial government receives 57% and the remaining portion of 5% goes to the local governments, after government has deducted



the contingency reserve (Heywood et al., 2007:76). The 57% of the overall allocation that goes to the provinces is split amongst the nine provinces. This split is known as the horizontal division of the equitable share grant. The provinces are entitled to the equitable share grant as stipulated in Sections 214 and 227 of the Constitution of the Republic of South Africa to enable them to carry out their statutory obligations. A province can use its own discretion about how to spend unconditional grants, unlike conditional grants that are earmarked for a specific programme or activity (Heywood et al., 2007:78). Funds amongst the provinces are divided based on relative need, different demographic and economic profiles. The equitable share is determined by a six component formula and a weighting is assigned to the components (Heywood et al., 2007:78):

- education (51%);
- health (26%);
- basic component (14%), based on provincial share;
- institutional component (59%);
- poverty component (39%); and
- economic component (1%).

## **2.5 Other legislation regulating national health care**

The legislation discussed below is important as it outlines the different purposes and developments for the achievement of the overall health system policy agenda.

### **2.5.1 National Health Amendment Bill, 2008**

The National Health Amendment Bill (2008) has a new chapter on the framework of health pricing. The chapter includes definitions of pricing, procedures performed and consumable and disposable items utilised by health providers or health workers. The chapter does not apply to the sale of medicine. The basic sections and chapters are enabled through the inclusion of quality standards to accompany the implementation of the Office of Standards Compliance and Regulations to and the Certificate of Need (CoN) (South Africa, 2008a). A CoN is a requirement for public and private health establishments and is a licensing mechanism for health establishments to improve the allocation and distribution of health resources across the country

(Pearmain, 2007:24). In Chapter 10 the Minister of Health has the responsibility to appoint a pricing facilitator and five assistants based on the requirements outlined in the National Health Amendment Bill. According to Grey and Jack (2008:35), much of the NHA has remained in abeyance since 2003 but much needed attention was given to affordability, in an attempt to introduce health insurance.

### **2.5.2 Choice on Termination of Pregnancy Act, 2008**

According to the Choice on Termination of Pregnancy Act (Act 1 of 2008), all women in South Africa have the right to terminate a pregnancy based on the Constitution and the government's commitment to the Convention on Elimination of Discrimination against Women (CEDAW). The Act was promulgated to shed light on the right to choose to have a termination of pregnancy (TOP) or to undertake an abortion with the assistance of health care workers (Grey & Jack, 2008:39).

Women may have a TOP without the consent of their husbands and partners as stated in the Act. Findings reveal that half of the women in South Africa have sufficient knowledge of having access to a legal TOP (Grey & Jack, 2008:40). Barriers preventing the realisation of this Act include health workers' refusal to carry out TOP processes, because they are motivated by religious and conscience factors. Grey and Jack (2008) suspect that these barriers impeding the implementation of the Act may result in the retention of very important information. The Act addresses this by ensuring that informed consent is given by the patient, after detailed discussions, including the advantages and disadvantages of the procedure, by health workers. Health workers who neglect to do this are in breach of professional ethics. The Act was amended and the objectives of the Amended Act were to:

- Allow registered nurses and midwives to perform a TOP.
- Allow the MEC of the province to designate TOP facilities.
- Allow private and public facilities that have 24hr maternity wards to do a TOP up to 12 weeks into pregnancy.
- Ensure that the MEC prescribes requirements and conditions where TOP takes place.

The Amendment Act aims to delegate monitoring, implementation and functioning of TOP from national to provincial level, thereby empowering MECs in the provinces to identify certain service gaps and address them.

### **2.5.3 Medical Schemes Act and 2008 amendment Bill**

The Medical Schemes Act (Act 131 of 1998) was passed into law and replaced the previous Medical Schemes Act (Act 72 of 1967). The Act provided for the reintroduction of community-rating and risk-rating to improve access and promote equity of medical scheme benefits to the sick and elderly. This was done because schemes had designed their benefits in such a way that those who become acutely ill ended up using public health sector facilities because treatment was too expensive in the private sector. Prescribed minimum benefits were also introduced by the Act. The Medical Schemes Act of 1998 constituted refinement of the existing Act that included:

- extending certain rights of members and dependants;
- regulating the practice of reinsurance;
- strengthening the Council and Registrar to act in the interest of the beneficiaries;
- regulating the marketing of medical schemes to ensure more frequent communication with the Registrar; and
- defining the circumstances in which the scheme can be inspected.

In 2008, the Medical Schemes Amendment Bill was tabled. The main focus of this the Bill is “the Risk Equalisation Fund (REF), the greater cross-subsidisation between members of medical schemes, improved governance of medical schemes and the emergence of risk-pooling medical schemes products for low income beneficiaries” (Grey & Jack, 2008:37). Depending on the envisioned Bill’s provisions, a REF will be created and information about the process and methodology will follow. The Bill also gives effect to strict regulations for the admission of beneficiaries, defining the basic and supplementary benefits and how costs are calculated using community-rating.

## **2.5.4 Medicines and Related Substances Act, 1997**

The Medicine and Related Substance Act (Act 90 of 1997) was amended to include provision for the parallel importation of medicines, establishment of a transparent pricing committee and the introduction of a transparent, non-discriminatory pricing system for medicines. This legislation was challenged by the Pharmaceutical Manufacturers in 1998, the New Clicks South Africa (Pty) Ltd and Pharmaceutical Society of South Africa. Regulations were untouched but the court ordered that technicalities in the Medicines and Related Substance Act of 1997 be clarified (Pearmain, 2007:22).

### **2.5.4.1 Medicines and Related Substances Amendment Bill, 2008**

In 2004, new amendments for the Medicines Act were published for comment. The Act was not finalised pending an inquiry headed by Prof Green-Thompson (Grey & Jack, 2008:35). According to Grey and Jack (2008:35), the findings of the task team differed from the proposals in the Bill based primarily on the role of the South African Health Products Regulatory Authority (SAHPRA). The task team recommended that the SAHPRA take responsibility for regulating all therapeutic products in South Africa. Therapeutic products include all human prescription medicines, African traditional medicines and complementary medicines. The team proposed that SAHPRA will integrate a number of fragmented entities or government organisations responsible for regulating health products. Proposals tabled in Parliament on the Bill allocate responsibility to the SAHPRA for certifying products (medicines, medical devices and others) based on evidence of efficacy, safety and quality. The SAHPRA will consist of a full-time Chief Executive Officer (CEO) and support. The CEO will appoint a committee to investigate and report to him/her. The Minister of Health is assigned the responsibility of registering products and medicines after consulting with the Minister of Agriculture. The Minister will be able to, with recommendation of the SAHPRA, exclude a medicine from any provisions in the Act.

The policy discussion not only had to come to a decision about whether or not the state will endeavour to establish a SAHPRA but also whether such a body will be employed on a part-time or a full-time basis.

## **2.5.5 Pharmacy Amendment Act, 1997**

Amendments to the Pharmacy Act (Act 53 of 1974) were made in 1997. The Act introduced the opening-up of pharmacy ownership in South Africa to non-pharmacists but these were subject

to requirements imposed by government. This was, however, not what took place in practice. Instead, there was consolidation and some growth within existing urban markets by large companies such as New Clicks Holdings, Pick n Pay and Shoprite Checkers (Pearmain, 2007:22-23). Entrepreneurs tend to locate their pharmacies in areas that are good for business. Because of these trends, the purpose of the legislative amendments is not achieved on a large scale. In 2007, the DoH reported that 192 pharmacies were issued with licences and that 30% of the new licences were owned by pharmacies located in historically disadvantaged areas (Pearmain, 2007:22-2). Under the Amendment to Pharmacy Act (Act 88 of 1997) in 2000, newly qualified pharmacists had to perform community work for the first time.

### **2.5.6 Health Professions Amendment Act, 2008**

The Health Professions Act (Act 22 of 2007) was approved in 2008. The Act assigned additional responsibility to the Health Professions Council's functions and indicated that the following documents should be submitted to the Minister of Health:

- A five year strategic plan after coming into office which includes a plan for fulfilling its objectives under the new Act.
- A bi-annual report about the status of the health professions and matters of public importance that have come to the Council's attention while performing under the Act.
- An annual report within six months of the end of the financial year.

The Council ensures that the annual budget is drawn up for its self and professional boards and that it and the professional boards operate within the budgetary framework. In terms of Ministerial supremacy, the national health policy determined by the Minister requires that the Council function within the legislative framework. Membership of the Council is not open to those who are "a member of a municipal council, a provincial legislature or Parliament or a national office-bearer or employee of any party, organisation or body of a political nature" (Grey & Jack, 2008:41).

## **2.6 Conclusion**

This chapter provided a legislative overview of the health care system. It can be seen from the information discussed, that policy makers must be mindful of the historical background that

shaped the lives of many people in South Africa. South Africa does not have a faultless health system but it has a well rooted framework aimed at achieving equity that guides the ever changing health needs of its society towards contemporary, effective legislation.

The next chapter gives a picture of the current health sector scenario in South Africa. Challenges that plague the health system are discussed and the steps that need to be taken to implement the NHI are also set out.

## **CHAPTER THREE**

### **CHALLENGES TO THE CURRENT HEALTH CARE SYSTEM IN SOUTH AFRICA**

#### **3.1 Introduction**

This chapter explains the inherent challenges that pose a threat to the realisation of equitable health care across income categories in the National Health System (NHS).

After apartheid the NHS of South Africa was transformed and government changed the priority of policy from voluntary insurance (also known as medical schemes) to public health sector development. The NHS is a two-tiered system, the public and private sectors, which cater for high- and low-income earners and the unemployed. Three categories of the population use health services in the public and private sectors. The first group are those who cannot afford private health care and rely on public services, second are those who pay for health care out-of-pocket, and lastly there are members of medical schemes.

#### **3.2 Outline of development in the health sector**

According to Coovadia et al. (2009:825), the history South African health care was characterised by facilities that were not only segregated but also separated in terms of curative and preventive services. The Health Act of 1919 the four provinces (Transvaal, Natal, Orange Free State and Cape Province), allocated hospital curate care and preventive health care responsibilities to the local authorities. From 1942-1944, the Gluckman Commission attempted to transform the health system. The Gluckman Commission recommended the development of a chain of health centres, which were to be the forerunners of community-based primary health care (Coovadia et al., 2009:825). In 1945, Gluckman became the Minister of Health, but the National Party assumed power in 1948 and the recommendation to redirect the health system was rejected (Coovadia et al., 2009:825).

Under the rule of the apartheid government, further fragmentation in health care was entrenched when the bantustans were created (Coovadia et al., 2009:825). Bantustans are territories set aside for black inhabitants. Bantustans acted separately from each other, like quasi-independent powers, with their powers controlled and manipulated by the government. By

the end of the apartheid era there were 14 different health departments which focused on the hospital sector, whilst the primary level services were underdeveloped. The health services in the Bantustans were systematically under-funded – by 1986/87 public health spending ranged from R23 per head in Lebowa to R91 per head in Ciskei. Coovadia et al., (2009:825) found that financial allocations ranged from R150 in the Transvaal to R200 in Natal and the Cape Province.

In 1948 the National Party government instituted apartheid legislation. From then onwards segregation ruled government decision-making, especially when separating those that had a high income from those with little or no income at all. It did this by following the example of the 1889 established voluntary private health care sector and built an underfunded public sector (McIntyre, Theide, Nkosi, Mutyambizi, Castillo-Tiquelme, Gilson, Erasmus & Goudge, 2007:14). The voluntary private health care sector was established in 1889, and was formally non-profit driven. Health care services were provided on work sites by employers to protect their employees. After the 1980s, the sector commercialised and government endorsed privatisation (Hassim et al., 2007). The apartheid government encouraged the growth of the private sector in order to reduce demand in the public sector, according to McIntyre, Gilson, Wadee, Theide and Okorafor (2006:1-2). Driven by international trends, the government ensured private sector growth through:

- Charging fees for specific health services and the growing membership of medical schemes (a form of voluntary private insurance).
- De-regulation, meaning that medical schemes charged those with higher risk of falling ill (such as old people with health conditions) more than the low-risk groups such as healthy young people.

Meanwhile in the public sector, which served the majority of African, Coloured and poor population groups, commercialisation was encouraged through:

- An increasing reliance on funding from user fees at public facilities.
- Public-private interactions where public money was used to purchase services from the private sector. Services purchased included things such as catering and laundry for public facilities (McIntyre et al., 2006:1-2).

The public sector subsidised the private sector by paying contributions to medical schemes for civil servants and providing tax subsidies for medical scheme contributions which benefited the



highest income earners. The negative effect of commercialisation on the poor sparked interventions from interested parties and health care committees to pressurise the government to be inclusive in formulating health policy (Van Rensburg, 2004:77). The fragmentation brought about by the progressive shift from public sector to private sector health investment led to the investigation of possible solutions.

### **3.3 National health system challenges**

The South African health system has undergone a major shift in priority, from advancing the needs of the rich, to focusing on the needs of vulnerable people. Many reforms have taken place since 1994. Primary health care has become the cornerstone of health care delivery in this regard. Coovadia et al. (2009:828) made known that change was evident in the clinic infrastructure programme in which 1 345 new clinics were built and 263 upgraded, improving availability and access to health care services. Mass immunisation campaigns reduced the incidence of measles in the country and accelerated the eradication of poliomyelitis (Coovadia et al., 2009:828). The issue of essential drug lists and standard treatment for primary health care and hospital care at all levels proved government's commitment to improving access to health care (Coovadia et al., 2009:828). The Health Professions Council's representation was changed by legislation to transform representation to reflect the makeup of the South African population. Although government has made great strides in changing the health system, there are inherent challenges.

The fundamental challenge to the government's mandate in terms of health care is centred on the achievement of access and equity. Aspects that give rise to the problems in the current health system include human and financial resources, the two-tiered health sector, the increasing number of users in the public sector, and the skewed consumption of services between the rich, middle and poor groups that is based on ability to pay. Rakoloti (2007) concur with these challenges and identify key strategic challenges as the growing misdistribution of:

- Financial, human and other resources between the public and private sectors, relative to the populations they serve.
- Health care resources available to different socio-economic groups within the population.

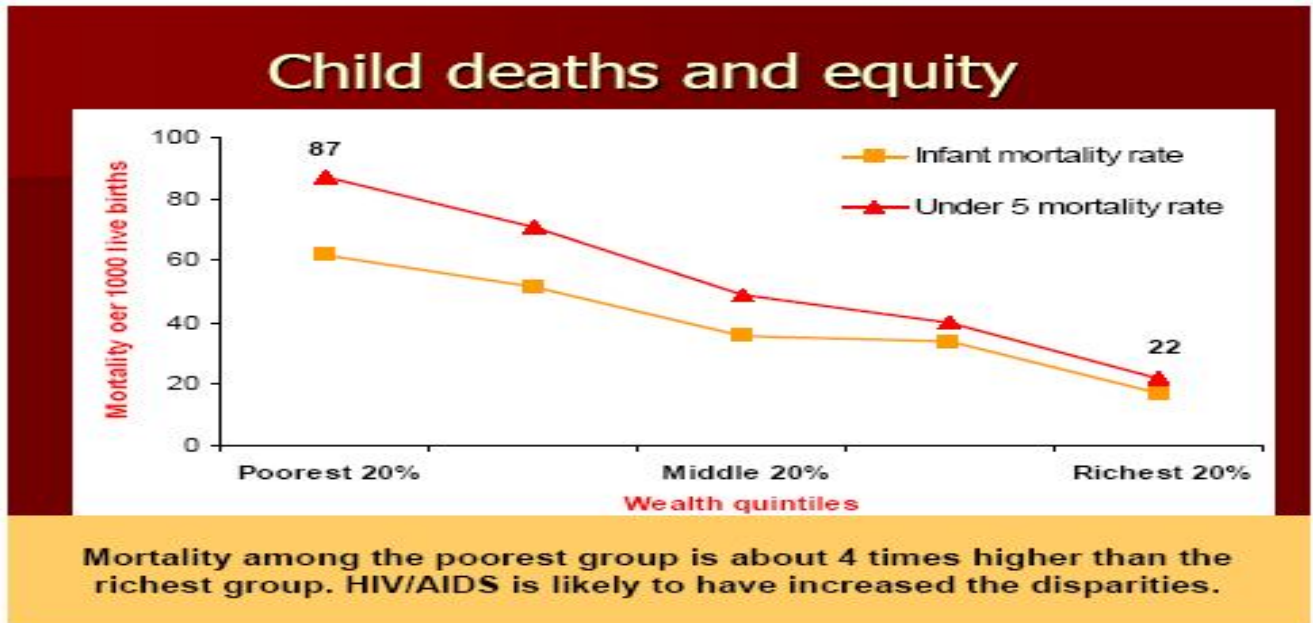
- All health care resources between and within provinces, which has been increasing over the past few years.
- Fragmentation of the health system based on separate financing and provision arrangement of different socio-economic groups.

### **3.3.1 Financial resources**

Financial resources within any system are integral when realising certain changes and/or consistent delivery of services. When there are financial constraints of any sort, if an efficient delivery of services is not provided then there could be the devastating effect of a service termination. The following sections explain the financial constraints experienced by patients and in the health system.

#### **3.3.1.1 Income inequality**

Lack of resources is a barrier that hampers equity, especially in the complete development of children. Poverty seems to prey on the vulnerable and defenceless. Chopra, Daviaud, Pattinson, Fonn and Law (2009:835) indicate that South Africa is amongst 12 countries which are experiencing an increase in child mortality since the baseline for the Millennium Development Goals (MDGs) were set in 1990. In low-income countries, one out of every 10 children die before the age of five but in wealthier nations it is one out of 143 (United Nations Development Programme, n.d.). Matlala (2008:226) states that “one is, therefore, forced to accept that the enemy of access to equitable and affordable health care, especially the private hospital care in S.A is poverty”. Figure 3.1 depicts Matlala’s assertion and provides evidence of the impact that poverty has on access to essential services.



**Figure 3.1:** Child deaths and equity

Source: Weber, Campbell, Caraj, Duke, English and Tamburlini (2007:30)

The figure indicates that the poorest quintile are more likely to have high infant and under five mortality rates than those who fall in the richest quintile. In the Western Cape, for instance, 28% of the population receives health care from the private sector, while 25% of the population is unemployed. The unevenness, according to Makinen, Waters, Rauch, Almagambetova, Bitran, Gilson, McIntyre, Pannarunothai, Ubilla and Ram (2000:63), means that health care is more accessible to those with higher health expenditures (the rich). According to Heywood et al. (2007:174), the rich are likely to make use of private health providers through funding mechanisms that will ensure access to health care through:

- membership of medical schemes or other forms of health insurance;
- out-of-pocket expenditure;
- access at their workplace; and
- non-profit and non-governmental organisations.

Unemployment leads to the total exclusion of 25% of the population from private health care and results in their dependence on the public health system. Makinen et al. (2000:63) mention that the wealthier group has a higher usage level of the private providers than do the remaining

groups. The inequality in usage levels has a direct bearing on the population in the Western Cape and causes further disparities in health care. The figures shown in Figure 3.1 indicate that there are financial limitations to health care, in that, 70% of children in the poorest quintile have the possibility of death, compared to 20% in the richest quintile. Wagstaff's (2002:101) study of nine Organisation for Economic Co-operation and Development (OECD) countries, found that inequality in health is not related to total health care expenditure per capita, the percentage spent publicly, or gross domestic product per capita, but associated with income inequality. Income inequality is noted between white and black population groups. Table 3.1 shows that less than one in every ten black African households (8,6) fall in the upper income quintile and almost half fall below the middle income quintile.

**Table 3.1:** Distribution of South African households by income quintile and population group of household head

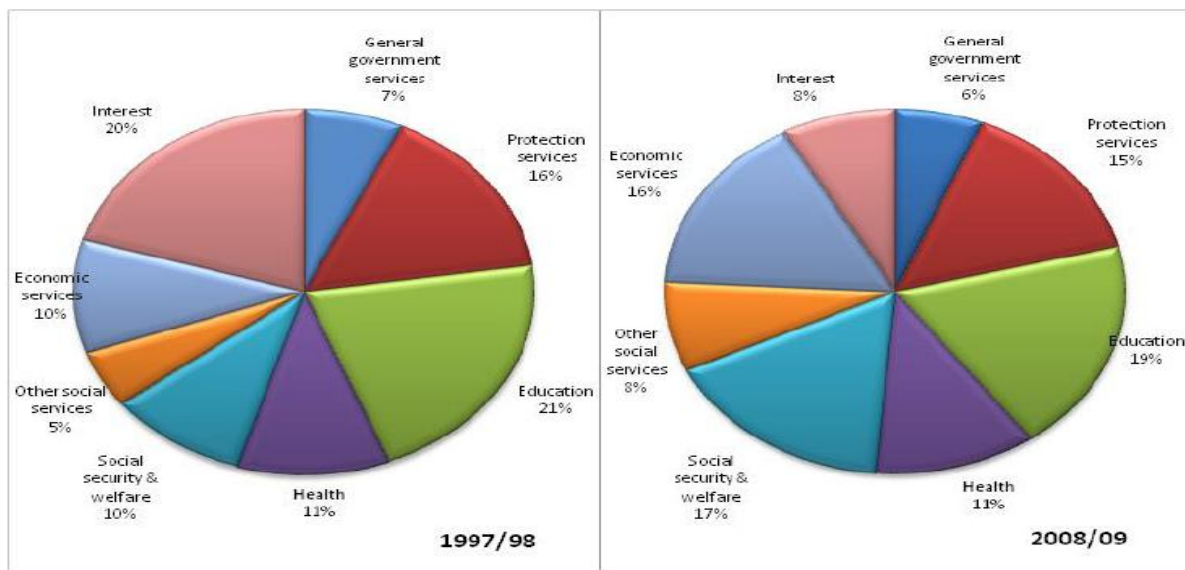
	<b>Black</b>	<b>Coloured</b>	<b>Indian/Asian</b>	<b>White</b>
Upper quintile (R90 467+)	8,6	27,5	46,0	78,8
4th quintile (R36 043 - 90 466)	19,5	29,3	28,2	15,4
3rd quintile (R20 203 - R36 042)	23,0	20,2	13,6	3,6
2nd quintile (R11 378 - R20 202)	24,2	13,8	8,1	1,0
Lower quintile (Less than R11 378)	24,8	9,2	4,2	1,2

Source: Statistics South Africa, Income and expenditures of households (2005/2006)

In the white population group, almost four out of five households (78,8%) have an annual income falling in the upper income quintile. One in every four black African households (24,8%) fall in the lower quintile while 1,2% of white households are in the same quintile. The evidence highlights high-income inequality in South Africa. This inequality is one of the main reasons why many people have to rely on the public health sector. Wagstaff's (2002:101) resolve can, in essence, be used as one of the possible reasons there are disparities in the mortality distribution.

### **3.3.1.2 National health system finance distribution**

Another barrier to health care access in South Africa, especially to resources, is not just the lack of resources, but their inefficient distribution on a national level, as shown in Figure 3.2 (Anon, 2008:1), in comparison to the population growth and human resources.

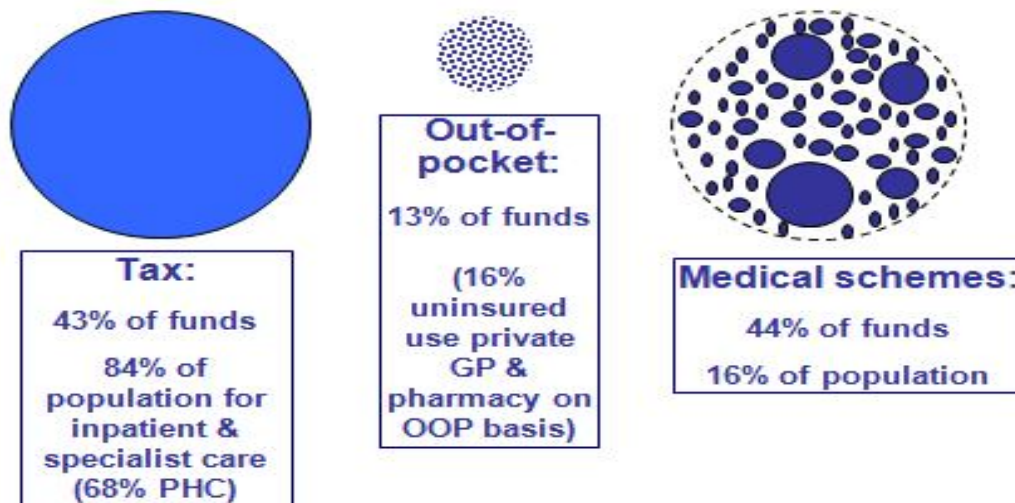


**Figure 3.2:** Distribution of government funds across sectors (1997/98 and 2008/09)

Source: McIntyre (2009:2)

Figure 3.2 shows that 11% of government funds were allocated to health care in 2008/09, the same percentage as in the 1997/98 financial year. Recent findings reveal that 12% was distributed in 2010 (Health-e, 2010). It is useful to note, as mentioned in Chapter One, that in 2008 the former Minister of Health indicated that annual government funding has flat-lined over the last 10 years at R1 000 per capita (*Businessday*, 2008). Discussions about human resources in this chapter will further uncover the fact that budgetary allocations do not keep up with population growth and have adverse effects on the delivery of services. Combining the different aspects concerning budgetary allocations – the health sector requires financial and other scarce resource injection to meet the health care needs of South Africans.

The fact that 40% of public health care spending is used for 85% of the population and 60% of private health care spending is used for 15% of the population is an indication of inequitable distribution of resources (Anon, 2008:2). For an overview, Figure 3.3 shows the difference in the fund allocation between the public and private sectors.



**Figure 3.3:** Fragmented pools (2008)

Source: McIntyre, 2010. Presentation: Health economics unit, University of Cape Town

Inequitable distribution is evident in the total health care finances divided amongst the three pools. The allocation of financial resources between the public and private sectors is approximately the same, whilst the population it serves differs broadly. If government funding is too low, or in this case, inequitably distributed, more services will be provided on an exclusive rather than on a shared public health system basis (Anon, 2002:45-46). This implies that when poor people are not subsidised by tax-based or mandatory systems, equity will not receive priority and people will not get the best possible health care (Anon, 2002:45-46). Makinen et al. (2000:63) support this view and recommend that an increase in the proportion of capital for services consumed by the disadvantaged groups will be integral in achieving access to health care. In addition, Makinen et al. identify building health facilities, placing more health personnel in disadvantaged rural areas and urban slums as potential strategies to achieve this goal.

### 3.3.2 The health financing contributing mechanisms in South Africa

McIntyre (2007) identified different contributing mechanisms that are used to finance the health sectors, such as:

### **3.3.2.1 Government funding**

Government funding generally constitutes tax, direct tax, personal and company income tax, indirect tax as well as value added tax and custom duties. Apart from accumulating government funds the general way, domestic and international loans can also be obtained to aid government activities. According to McIntyre (2007:3), "... donor funding from bilateral or multilateral international organisations may take the form of loans, which have to be repaid along with interest charges, or of aid grants, which do not have to be repaid".

In general, governments have many commitments to ensure that the needs of a country are met under this contributing mechanism. Government' financial resources are stretched across many sectors and as result the health injection is not aligned with the burden of the risk pool in the public sector (Figure 3.3). For instance, in South Africa and many other developing countries there has either been the need to make financial injections to defence or other social development departments, leaving the health system under-funded. In the case of South Africa, with debt reduced in the 1990s, resources were released and mainly allocated to social security services because of the introduction of child grants and economic services (McIntyre, 2009:3).

### **3.3.2.2 Health insurance**

Two main types of health insurance namely, mandatory and voluntary insurance are explained hereunder.

- **Mandatory insurance**

Mandatory health insurance refers to the requirement by law for citizens to become members of a scheme and make contributions. It is a combination of NHI and social health insurance (SHI). Mandatory health insurance is also called SHI in a system where only certain groups are required by law to be members or make insurance contributions in order to have health coverage. NHI is also a form of mandatory health insurance, but NHI extends cover to the whole population, including those who do not make contributions. In essence, it can be said that NHI is a form of universal coverage. Universal coverage is defined "... as a health system that provides all citizens with adequate health care, regardless of their employment status or any other factors" (McIntyre, 2007:xii).

- **Voluntary insurance**

Voluntary health insurance (VHI) was historically reserved for the high-income groups. VHI is generally employment-based, where company employees join a health insurance scheme. The contributions to the scheme are made by both the employer and the employee. Another form of VHI is community-based insurance. Tabor (2005:13) indicates that “community-based health insurance is any program managed and operated by a community-based organisation, other than government or a private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of the health care services”. It is sometimes called mutual insurance.

In South Africa voluntary insurance is existent since 1889 as referred to in Chapter 2, and the mechanism used in the private sector. Cost-spiralling and cream skimming, as discussed in Chapter 1, are challenges facing the voluntary insurance or private sector. Mandatory health insurance have not been employed in South Africa, but debate about the implementation and the suitability thereof started from 1936 until currently, hence this research was conducted.

### **3.3.2.3 Out-of-pocket payments**

Out-of-pocket (OOP) payments are made by the patient to the health provider at the point of delivery. Co-payments by medical scheme members are another form of out-of-pocket payments as well as contributions paid at public facilities. McIntyre, Garshong, Mtei, Meheus, Theide, Akazili, Ally, Alkins, Mulligan and Goudge (2008:872) state that “out-of-pocket payments represent the most extreme form of fragmentation as they place the burden of health-care funding on an individual and translate into health service use, and hence benefits, being distributed according to ability-to-pay rather than need for health care”. Out-of-pocket payments account for one third of health care in all low-income countries (Drechsler & Jutting, 2005).

South Africa has a two-tiered system, public and private, in which all contributing mechanisms are included. These two tiers of the health system are financed through several mechanisms: individual and company insurance contributions, out-of-pocket payments, government tax subsidies and the tax-funded public health sector. The government contributions, under each mechanism, shown in Figure 3.3 indicate that inequalities exist in the health sector in South Africa. The consequence is that, if there are many risk pools, then this results in fragmentation of risk amongst small risk pools and in the event that a small health insurance scheme has to make a prediction of the member’s risk, that risk will not necessarily translate into future costs



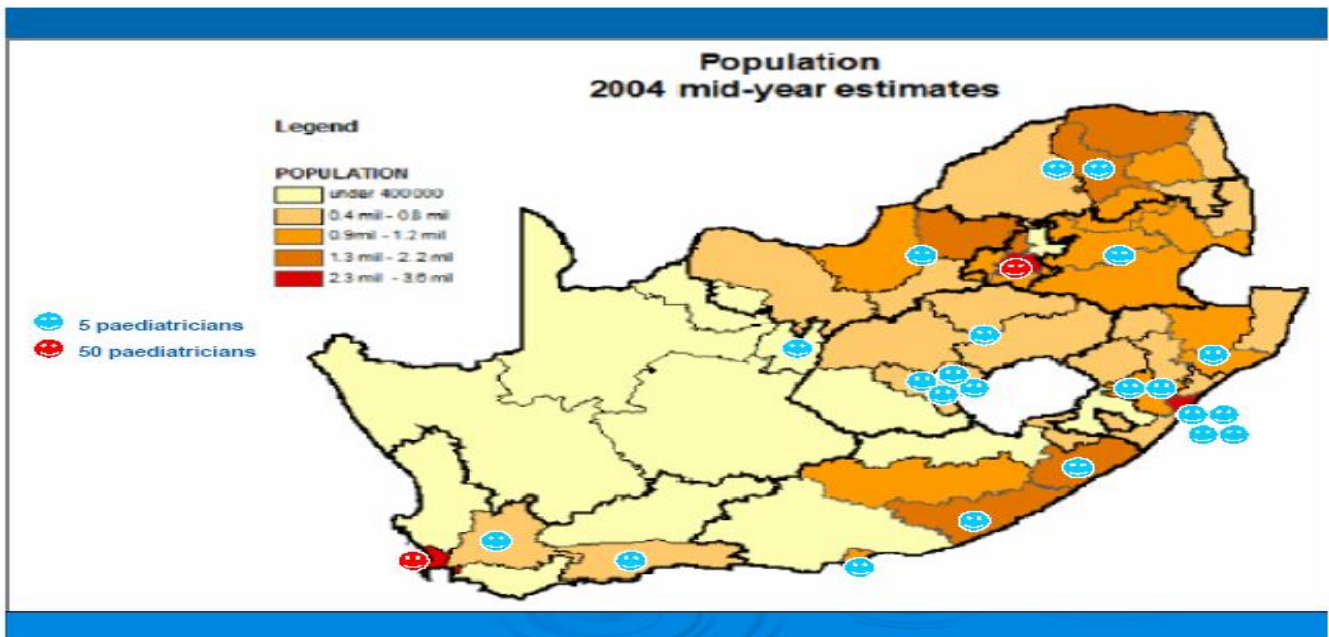
needed to cope with unexpected expenditure levels or high health care costs in the event of an epidemic (McIntyre, 2007:34).

Inequality is depicted in the 43% of tax funds that have to cover 84% of the population, while 44% goes to medical scheme funds which only have to cover 16% of the population. In terms of financial coverage on an annual basis (Mutymbizi, n.d.:2-7), 14.4% of the population have secured health services in the private sector with R9 700 spent per beneficiary in 2005, 21.1% of the population pay out-of-pocket in the private sector for primary care, but depend on the public sector for hospital care. Annual expenditure per capita, which includes out-of-pocket payments to the private and public sectors, amounts to R1 500 per person in 2005. About two thirds of the population (64.5%) is entirely dependent on the public health sector for all health services. Less than R1 300 is spent per annum on people using the public sector.

Financing is important to a health system because is it the “mother’s milk of health care” (Hsiao, 2007:950). The health care challenge in South Africa, in terms of financing, is directed to the inefficient and inequitable management thereof (McIntyre & Theide, 2007:36). Hsiao (2007) does not refer to health care financing as the solution to improve the health sector but identifies financing methods employed in a country as the definitive factor for determining the risk pool (sharing risk across a group or the entire population) and the distribution of the cost-burden (the burden of paying for health care). Carrin, Evans and Xu (2007:652) acknowledge the method of financing the health system is important. They state that: “how health systems are financed largely determines whether people can obtain needed health care and whether they suffer financial hardship as a result of obtaining care”.

### 3.3.3 Geographic access

McIntyre and Gilson (2002:1647) state that "... financial access must, thus, be accompanied by improvements in geographical access if it is to address the needs of the relatively under-served and most vulnerable". Weber, Campbell, Caraj, Duke, English and Tamburlini (2007:29) provide a map of the distribution of paediatricians across South Africa. This distribution serves as a microcosm of the need for geographic access to all health care services.



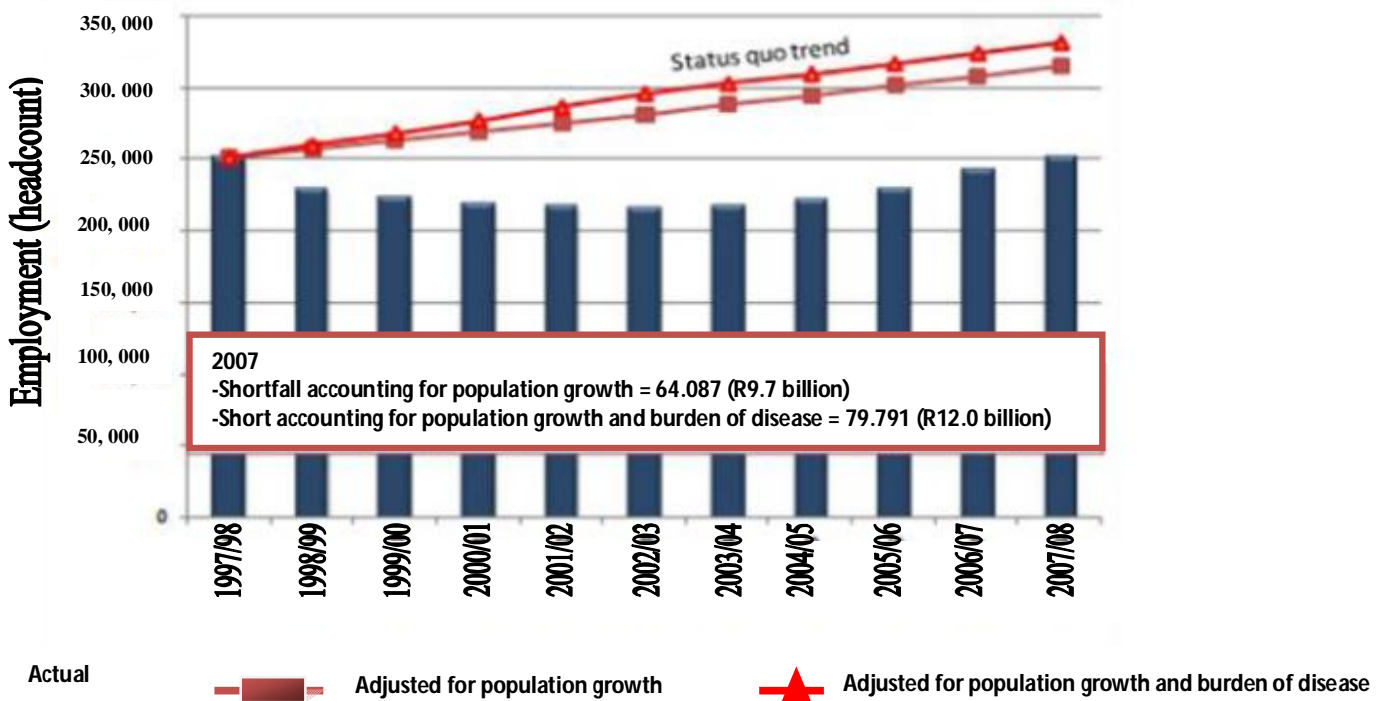
**Figure 3.4:** The number of paediatricians in South Africa, 2004  
Source: Weber, Campbell, Caraj, Duke, English and Tamburlini (2007:29)

From a holistic perspective in terms of Figure 3.4, two aspects are brought to the fore: the need for distribution and the need for retention of health professionals especially in South Africa. The distribution of paediatricians is skewed towards the Gauteng and Western Cape provinces. This maldistribution can be attributed to the movement of paediatricians from public to private health sectors, rural to urban areas and from primary to tertiary levels in the health system (Loewenson & Thompson, 2003:7).

### 3.3.4 Human resources

In the 1990s South Africa's health system experienced a decline in financial injection. This was as result of government's macroeconomic policy, Growth, Employment and Redistribution

Strategy (GEAR). The strategy, implemented in 1996, caused a strain on available funds based on the resolve that public expenditure growth should be lower than overall economic growth (Van Rensburg, 2004:382). According to Van Rensburg, the macroeconomic policy suggested that government's ability to fund improvements in the health sector became negligible. McIntyre et al. (2007:2) agree that public health sector staffing levels fell in this regard. Figure 3.5 shows the effects the policy had on employment growth in comparison to population growth. The figure shows that in the 2007/08 period if the employment rate had grown with the population, the public sector would have needed an extra 64,087 health workers.

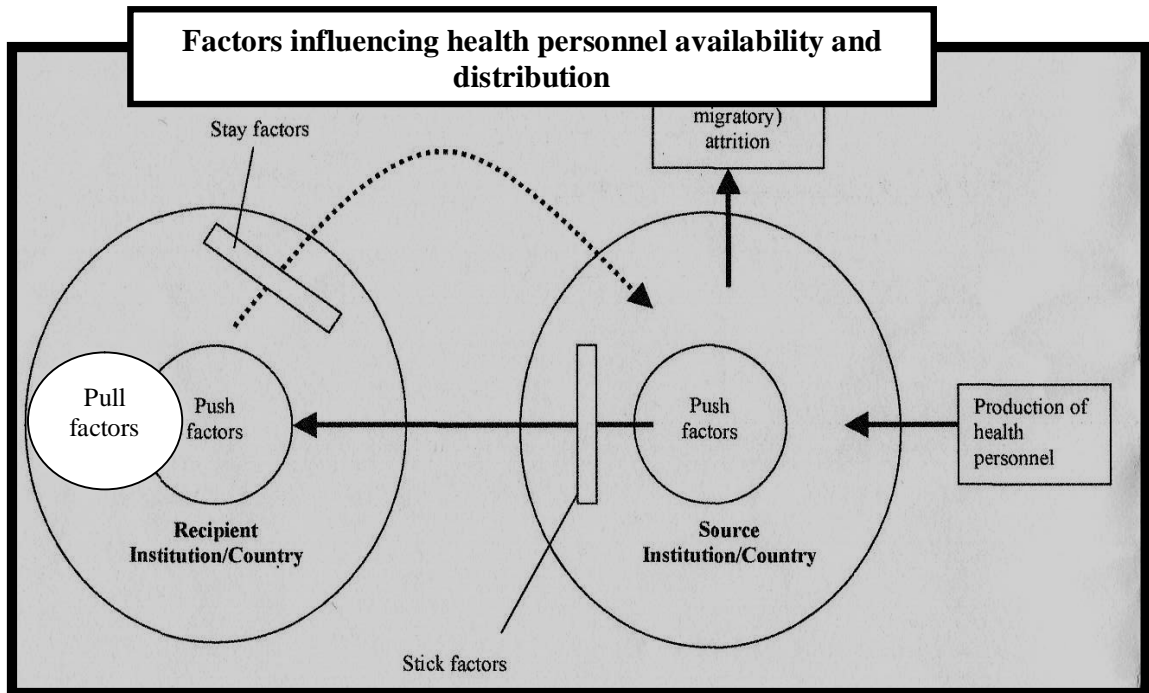


**Figure 3.5:** Public sector employment trends (headcount), from 1997/98 to 2007/08

Source: McIntyre, 2010

Apart from having unequal health service distribution, there is an increasing need for physicians to stay in the country. Waters (2009) from the Democratic Alliance notes that there is a 37% increase (from 2006 to 2008) in the medical professionals applying for a Certificate of Good Standing (CoGS). Four thousand medical professionals applied for CoGS (Waters, 2009). According to Waters, a CoGS is only needed by a medical professional who intends to leave the country. Many factors cause medical professionals to leave a country. Loewenson and

Thompson (2003:10-13) define them as push, pull, stick and stay factors. Figure 3.6 provides a breakdown of these factors.



**Figure 3.6:** Factors influencing health personnel availability and distribution  
Source: Adapted from Loewenson and Thompson (2003:13)

Pull factors attract professionals to a recipient country or institution. Dovlo (2003:4) states that “pull factors are deliberate and/or unintended actions that attract health professionals originating from the recipient country’s policies and actions”. Based on Dovlo’s explanation, it can be understood that the source country can also exercise pulling forces on persons who migrated, causing them to return. Push factors encourage personnel to leave their institution or the source country. Stick factors are made up of reasons that keep people where they are despite the push factors, and stay factors prevent a person from a recipient country from returning to the source country or country of origin (Loewenson and Thompson, 2003:10-13).

For the purpose of analysing Figure 3.6, Loewenson and Thompson’s view is interpreted as follows. Developing countries spend and sometimes borrow money from developed countries in order to produce health professionals. Many developing countries have newly-implemented

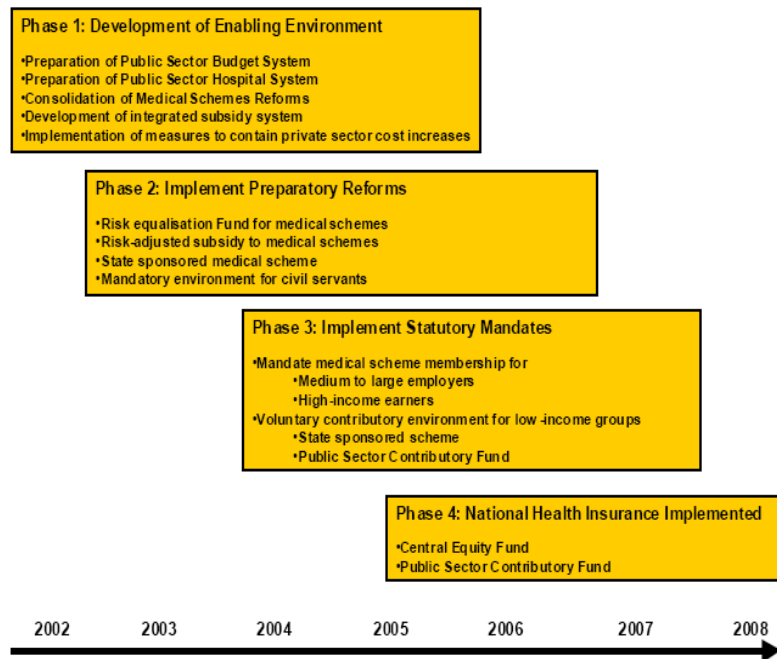
health systems that, because of growing pains, result in the formation of push factors within the health system. Loewenson and Thompson call them endogenous (health system) push factors. They include things such as remuneration and salaries, lack of job satisfaction, work associated risks and lack of further education and career development opportunities. Factors that dominate outside the health system are quality of life, war, civil conflict and political repression, and lack of education opportunities for children. As mentioned in the last paragraph, there might be stick factors that cause a person to stay in the source country or institution. Stick factors include high levels of morale amongst health workers and rewards or incentives. These are also the factors that pull medical professionals to move to developed countries. Pull factors include countries with a better quality of life, freedom from political persecution, freedom of speech and educational opportunities for children. Factors causing health professionals to stay in a recipient country are: the development of new social bonds, the risk of disruption to the education of their children, a reluctance to disrupt new lifestyle patterns and a lack of knowledge of job opportunities in their home countries (Loewenson & Thompson, 2003:13).

### **3.3.5 Management capacity**

After 1994, it was government policy to ensure that there was an increase in the proportion of women and black people employed at senior and top management levels. As a result of this policy, appointments were made with a lack of focus on competence (Coovadia et al., 2009:830). Inexperienced managers have struggled under the onerous responsibilities as well as the transformation. As a result insufficient attention was given to human resources, training and supervision (Coovadia et al., 2009:830). There was an overall deficiency of political will and leadership to manage underperformance. The tendency to retain incompetent senior staff and leadership became a miasma throughout the public sector. Loyalty became more important than accountability and the delivery of services (Coovadia et al., 2009:830). Coovadia et al. (2009:830) bluntly state that incompetence became widespread in South Africa because of the legacy of apartheid and inadequate education. The management of public hospitals is becoming an increasing concern and an impediment to the delivery of efficient and effective health services. Democratic Alliance leader, Helen Zille notes that “bad management, not the lack of funding, is the main reason for the deteriorating state of South Africa’s health system” (*Mail and Guardian*, 2009). Coovadia et al. (2009:831) suggests that these challenges can be addressed with political will power to change the focus and attitude towards accountability, rewards and the delivery of services which will produce competence and performance.

### 3.4 Steps towards national health insurance

Against the contextual setting, in terms of the political and health challenges, the government's strategy to address NHI can be seen as a series of phases. The National Department of Health developed a reform strategy in 2002, indicated in Figure 3.7 and discussed below.



**Figure 3.7:** Reform strategy and approximate timeline

Source: Department of Health (2002:138)

The reform strategy consists out of four phases. The purpose of each phase is to make gradual reform of the NHS into NHI system.

- Phase 1: Development of enabling environment

Phase 1 refers to the creation of a centralised public sector budget system which will provide for the implementation of national policy in provincial spheres. If a centralised system is too risky, the option of conditional grants can also be reviewed. Phase 1 also includes the preparatory aspects of the management body responsible for conditional grants. The tax system is addressed as a tool for risk-pooling. The tax subsidy system is noted to be of importance to income-related cross-subsidies. There is also a strong emphasis placed on cost containment in

the private sector and non-medical expenses are identified as the cause of ballooning costs. Therefore, administrative costs of open schemes and the annual increases should be controlled by being capped.

- Phase 2: Implementing preparatory reforms

Phase 2, which is the implementation phase, concentrates on establishing the statutory risk-equalisation fund. This fund will replace the subsidy system to ensure that all medical schemes maintain the same demographic structures in the market to distribute risk-adjusted subsidy to the medical schemes. Subsidies will be funded through general taxes and subsidy coverage will be determined by the values of public services not utilised by individuals who are not receiving cover in the private sector. The creation of a low-income state sponsored medical scheme is also incorporated with particular reference to the phased-in employer-employee relationship in terms of medical scheme membership.

- Phase 3: Implementing statutory mandates

The focus of Phase 3 is on the high- and low-income groups and their membership. Pertaining to the public sector, it is envisaged that a pre-payment system be established for high- and low-income earners. The idea is to eliminate the fee for service component and those who do not comply with this regulation will receive limited services.

- Phase 4: National health insurance implemented

Phase 4 is the final stage that ensures the single universal contributory system. At this stage there is an integration between private medical schemes and the public sector managed and controlled system, and all contributions, from whatever source, will be distributed to the Central Equity Fund (CEF). The system will fund the basic public sector services, non-medical scheme members and subsidise members of medical schemes. High-income groups, under a mandatory system, must belong to a medical scheme to ensure that their contributions form the basis for cost containment in the private sector. Low-income earners can choose between medical schemes or access to public amenities via the Public Sector Contributory Fund (PSCF). Low-income earners who work in the formal sector will have to make their contributions to the same fund. Both the CEF and PSCF will function within a statutory framework established by the Minister of Health.

Thom (2009:9) states that before the NHI can be implemented government must address certain issues such as:

- human resources problems;
- infrastructure problems, especially in terms of hospitals;
- establishing an effective procurement and supply chain
- implementing a proper information technology system;
- putting proper monitoring and evaluation systems in place, in order to understand the disease burden;
- finding an effective system through which to collect revenue;
- addressing issues of budgeting;
- ensuring that the proposed system meets constitutional obligations; and
- issues of accessibility to NHI, especially for people who are permanent residents.

The Minister of Health has not yet released a revised strategy for implementing the NHI as proposed by the African National Congress.

### **3.5 Conclusion**

The NHS, as disclosed in this chapter, has many health system related challenges threatening the health care of South Africans. The statutory obligations imposed on the state are only completely achieved when the limitations to citizens' constitutional rights are regulated against. There is much need for government intervention in terms of the current health sector environment to overcome the obstacles inherited from apartheid. Challenges ranging from poor management of hospitals to risk rating in the private sector should urgently be addressed because citizens' health depends on these issues being resolved.

The ANC-led intervention includes transforming the NHS into a NHI scheme. The next chapter will provide an analysis of the international health care models options available to address these challenges. The best suited option is discussed in Chapter Six.



## **CHAPTER FOUR**

### **INTERNATIONAL HEALTH CARE MODELS**

#### **4.1 Introduction**

The purpose of this chapter is to examine the different health care systems and the effects they have in and on different countries. In considering health reforms, it is important to analyse a range of possible health care models, including health system organisational structure, financing, and management of health resources. The models discussed in this chapter are the Beveridge model, Bismarck model, National Health Insurance model and Out-of-pocket model. A National Health system is very complex and important to a country's overall wellness, if there is a lack of policy focus and resources the whole country will be disadvantaged and many other sectors will be affected. To ensure that inequalities are addressed, there may be a requirement for 'control knob' mechanisms or large scale reforms. Health care reform is not a very recent idea, but as will be mentioned in this chapter, regions in other parts of Africa have also undertaken health care changes. The general goal is to ensure that the whole population is covered and those who cannot afford to pay for their own health care are included in national health care provisioning.

#### **4.2 Health care systems**

Van Rensburg (2004:3) outlines four basic components of a national health system that can be identified by answering four questions: who pays for health care, which provides services and benefits, who regulates the system and makes the decisions and who owns the institutions of health care. These questions will form the underlying themes of each health care model as discussed in the context of different countries. There are differences between health care systems and a national health care system, according to Van Rensburg (2004:3). Health care systems are those institutions in a society that deliver health care services to the population. A national health care system is generally regarded as mainstream health care funded and administered by government consisting of the "... totality of policies, programs, institutions and actors that provide health care..." (Van Rensburg, 2004:2). Reid, an economist, was assigned to analyse the different health care systems in the world to compare and make recommendations for America's health reform. Reid (2009) identified four health care models, namely: Beveridge, Bismarck, National Health Insurance and Out-of-pocket. The other two

types of health care systems under Cockerham's (Van Rensburg, 2004:14) fourfold classifications are Free-market medicine and the Semashko model. Free-market medicine refers to a system of health service fees charged at point of delivery where the doctor can provide same-day services, have more flexible hours and spend sufficient time with patients (Brook, 2006). In essence, the patient is the customer and not the insurance company or the tax payer according to Brook (2006). In this system, the middle man who adds extra cost, is eliminated, the patient receives quality health care and can request to be attended to on a house-call basis. The Semashko model is a state-provided, controlled, financed system and is free to all citizens. There are no third-party organisations between the health care providers and patients (Van Rensburg, 2004:14). The Semashko model was used by countries in the former Eastern bloc but no longer exists, according to Karjalainen (1998:1468).

#### **4.2.1 Beveridge model**

This model was named after William Beveridge (Hamilton, 2009a). Beveridge was an economist and social reformer and closely associated with the development of the welfare state (Ploug, 2003). After World War II, the British government commissioned Beveridge in 1941 to report on ways to rebuild the country. In 1942, the Prime Minister, Clement Attlee, announced the introduction of a new welfare state as outlined in the 1942 Beveridge Report. The 1942 Report provided recommendations for government to find ways of fighting the five grand evils of want, disease, ignorance, squalor, and idleness. The new welfare state also included the establishment of a National Health system (BBC Historical Figures, n.d.). The Beveridge model is government-funded but there are also private options available. The government provides hospitals, clinics, and doctors to all citizens. Under the Beveridge model, the government is the sole payer and has control over what doctors can do and what they can charge (Frontline, 2009). Citizens do not pay any bills but tax contributions which, according to Hamilton (2009a), are a hefty 17.5% of sales tax. Countries like Spain, Scandinavian countries and Italy apply variations of this model. The Beveridge health care model is discussed to illustrate how the application of a theory can vary.

##### **4.2.1.1 Scandinavian countries**

The Scandinavian countries are Norway, Denmark and Sweden. These countries share a common history in terms of their unification under the Kalmar Union from 1397 to 1523. After the countries broke up they remained unified in some areas, and finally gained independence in

the 20<sup>th</sup> century (Magnussen, 2009:63). According to Magnussen (2009:63), the history of the Scandinavian countries has laid the platform for the common approach to social welfare. The Scandinavian model of health care, internationally known, is dominated by the state's controlling role in formulating welfare policies in parallel with an extensive public sector participation for the implementation of these policies (Magnussen, 2009:63).

The health care system is based on the principles of universalism. This means that everyone is included and receives health care irrespective of any social class, income, or place of residence. Universalism is achieved under state control, limited market-based incentives, and policy limitations in the form of waiting lists (Magnussen, 2009:64). The health system functions within a decentralised public model which includes political bodies at local, municipal, or county levels to take responsibility for providing necessary health care services to the population (Magnussen, 2009:64). Over the period of 20 years much has changed, however the principles of the system have been left untouched. All Scandinavian countries were given the choice of health care services. Choice was once deemed as unnecessary to the market-based system. A market-based system of financing is regulated by fixed pricing of the supply and the demand of the consumers, and not by government or other bodies (Financial-dictionary, 2009a). Users are now allowed to choose between different hospitals, but politicians and the public are still not in favour of choosing between doctors.

Sweden and Denmark are members of the European Union (EU). Their membership carries with it substantial external pressures to reform from a laid back, flexible Scandinavian model to one with more detailed regulations (Magnussen, 2009:64). The financing methods have also changed from annual adjustments to sophisticated contracts by splitting providers and using activity-based financing to improve performance quality and increase efficiency (Magnussen, 2009:64). Activity-based financing or budgeting is dependent on determining those things that drive the order of activities order to ensure that quality and quantity of services are provided (Financial-dictionary, 2009b). Financing of the Scandinavian health system generally comes from government taxation; Sweden receives county-level taxation. Voluntary health insurance (VHI) is used by the population as a supplement to publicly-financed health care. A VHI is chosen and paid by employers. Membership of VHI varies among the countries, 2% in Norway, 4.5% in Sweden and 14.5% in Denmark (Magnussen, 2009:66).

#### **4.2.1.2 Spain**

The Spanish health system operates under a decentralised system, with the primary responsibility of implementing the universal system allocated to the 17 regions (Tanner, 2008:14). Decentralisation in Spain is basically characterised by the coordination between the State and Autonomous Community Health Departments that make up the national health system (Peralta, 2006). The federal government provides financial resources to each region with a block grant (Tanner, 2008:15). The health system is paid through tax and is included in the budget of each Autonomous Community (Peralta, 2006). Block grants are primarily based on the region's population as well as other factors that include population demographics. Regions may decide how to use the grants because they are not earmarked for specific purposes, and they can supplement the grants with their own funds. There is a great difference between the regional expenditure and availability of resources. That is why block grants are not the same for all regions.

The services provided under the Spanish health system include primary and general care, outpatient and inpatient surgery, emergency and acute care, long-term disease management and prescription drugs (some drugs may require co-payment). Services such as pharmaceutical and orthopaedic prosthetic services are co-financed by users (Peralta, 2006). Other services paid for on an out-of-pocket basis cover many different mental health services, some outpatient services and cosmetic surgery. In terms of physician choice, Spaniards may not choose a physician or a specialist because they are assigned to a primary care physician list in the local community and that doctor will refer them to a specialist. Waiting lists in Spain are very long, for this reason Spaniards choose alternative private insurance (Tanner, 2008:15). Approximately 12% of the population have private insurance; this creates double coverage because private insurers cannot opt out of the government system. As a result, a two-tiered system is developing in which the wealthy can purchase "...their way around the defects of the National Health System" while the poor do not have a choice (Tanner, 2008:15).

#### **4.2.1.3 Italy**

According to Donatini, Rico, D'Ambrosio, Scalzo, Orzella, Cicchetti and Profili, (2001:19), Italy's "health care system is a regionally based national health service that provides universal coverage free of charge at the point of service. The system is organised at three levels: national, regional and local".

Tanner (2008:12) outlines the responsibility of the central government, which:

- sets goals on how finances should be spent;
- monitors the overall health status of the nation;
- negotiates the labour contracts of medical staff; and
- set essential levels of care that the regions must meet.

Regional governments control their own autonomous budgets and allocate resources to the local level (Tanner, 2008:13). Local Health Authorities established by the regional government are responsible for providing government-run hospitals and clinics or contracting with private providers (Tanner, 2008:13).

The health system is financed through payroll and general taxes while the remainder comes from federal and regional general taxation and income and value-added tax. Resources are redistributed between the regions to compensate for inequalities. In terms of co-payments, 30% of services are paid through this method, but nearly 40% of the population is exempt from co-payments (including the elderly, pregnant women, and children). Co-payments are needed for diagnostic procedures, specialised and prescription drugs.

Health services provided under the government system include in-patient and primary care. The physician choice is limited in Italy because the population must register with a physician within their Local Health Authority (LHA). General practitioners refer patients to the required institutions where more specialised care can be provided (Tanner, 2008:14). Private health insurance, usually provided by employers, is available but is not very widespread as it covers only 10% of the population. It is impossible to opt out of the National Health System and health premiums are not tax deductible. That is why such a small group of private health insurance members exist (Tanner, 2008:14).

#### **4.2.2 Bismarck model**

The Bismarck model is named after Otto von Bismarck (Ploug, 2003). Bismarck was against the growing social movement which represented a poor distribution of power and passed a series of laws to stunt its growth (Tetrahedron, n.d.). Bismarck's government was consolidated by the Social Democratic Party. The Bismarck model is run largely by private hospital doctors and

insurance plans. People resident in countries using the Bismarck model must have some form of insurance. The insurance companies work on a non-profit basis, and are bound by law to keep people with pre-existing health conditions. The Bismarck system provides for short waits, quality care and low costs (Hamilton, 2009b). An insurance system is used in this model; the insurers are called “sickness funds”. The funds are usually jointly financed by employees and employers through payroll deductions (Tetrahedron, n.d.). This is a multi-payer model, but tight government regulations ensure cost-control that the single-payer Beveridge model provides. Countries, as discussed below that make use of this model include Germany, France and Japan.

#### **4.2.2.1 Japan**

Japan provides universal coverage through three categories of insurance: Employer-based insurance, National Insurance and Insurance for the elderly (Kaiser, n.d.). The health system is financed by national government and private employers' individual co-insurance payments. Health care is provided through privately-operated hospitals and clinics. Coverage includes in - and out-patient care, dental care, some pharmaceuticals and some cash benefits.

According to Arai and Ikegami (1998:29) the Japanese health system is broadly divided into the insurance system for employees and their dependants and the insurance system for the self-employed, their dependants, and pensioners. Employer-based insurance provides coverage for employees of companies with more than five but fewer than 300 workers (Kaiser, n.d.). This insurance covers 30% of the population and contributions are made through premiums that are fixed and split between employees and employers (Kaiser, n.d.). Cost sharing between the employer and employee amounts to 30% out-patient and 20% hospital care. Employer-based insurance is subdivided into three schemes, namely: Society-managed plans, Government-managed plans, and Mutual aid associations. Society-managed plans are for employees at large companies and funded by employers and are subsidised by the government, forming health insurance societies. Government-managed health insurance is for small - and medium-sized companies. This insurance plan's benefit costs and administrative costs are covered by the Japanese government. Mutual aid association cover civil servants and teachers and receive no funding from the government. The Mutual aid associations cover 8% of the population.

National Health Insurance is for those eligible for employee-based insurance (Kaiser, n.d.). The target group, which forms 34% of the population, includes farmers, self-employed, unemployed,

retirees and expectant mothers. Premiums are split between employees and employers. Depending on the insured's ability to pay and in the absence of an employer, the state pays a portion of the premiums. Health insurance for the elderly also includes those who are disabled (Kaiser, n.d.). The benefits are for the elderly, that is 65 years or older, and those who suffer from disabilities from the ages 40 to 64. The insurance scheme provides long-term health care such as home care, respite care and institutional care based on the need of the elderly individual. Most of the funding is covered by the insurance and the member has the responsibility to co-insure at a rate of 10%.

#### **4.2.2.2 Germany**

Germany's health system is mandatory for those who earn less than Euro 3,862 gross per month in 2004, meaning that everyone who falls in this category must join one of the 300 sickness funds (Green, Irvine & Cackett, 2005). Those with higher incomes can opt out of the state services and purchase health care from private insurance (Tanner, 2008:29). Although private health insurance is optional, many remain in the state system; 10% of the population are voluntary health insured (Green, Irvine & Cackett, 2005). Sickness funds are financed through payroll tax – a split between employer and employee contributions – and 15% of the wages are contributed (Green, Irvine & Cackett, 2005). The sickness fund makes provision for those who cannot work due to illness. Coverage ranges from 70 – 90% of the last salary of the patient and over a period of 78 weeks. On average, Germans have to make a contribution of 13% in co-payments as a means to curb the increase in expenditure. The German health system is regulated by the central and state governments (Tanner, 2008:30).

Central government establishes global budgets, defines new medical procedures to be included in the benefits package and set reimbursement rates for physicians. Some of these responsibilities are accomplished through legislation and the duties are negotiated between the National Association of Sickness Funds and the National Association of physicians. The Sickness Funds and physicians negotiate their overall budgets, reimbursement contracts for physicians, and determine the procedure for monitoring physicians as well as the reference standards for prescription drugs. Benefits packages include physicians, hospital and chronic care, diagnostic tests, preventive care, prescription drugs and part of dental care.

#### 4.2.2.3 France

Reid (2009:51) views the French health system as a variation of the Bismarkian system as it is based on the sickness funds that began in 1928. The largest fund is the General National Health insurance scheme which covers 83% of the population. Separate insurance plans cover agricultural workers, self-employed, special occupations like mining, transportation workers, artists, clergy and public notaries. The last fund covers the unemployed. The funds are divided according to geographic region.

The whole population must belong to an insurance fund, but the employed and pensioners are provided with coverage through their employers who pay most of the cost (Reid, 2009:51). Contributions are mainly made from payroll tax as it is the largest source of funding in France. Employers contribute 12.4% of wages; employees 0.75% of wages, income tax constitutes 5.25% and dedicated taxes are assessed on the revenues of tobacco, alcohol and pharmaceutical companies.

The benefits package comprises in-patient care, out-patient care, physician and specialist care, diagnostic testing, prescription drugs and home care services. Extensive co-payments are required for most of these services and range between 10 and -40% of the cost. Due to the high cost of co-payments required, complementary insurance assists in relieving the cost burden to French patients. Complementary coverage can be sought from non-profit cooperatives or for-profit insurance companies (Reid, 2009:31). In the private insurance market there are no guiding government regulations, although government regulates in terms of the benefits included in coverage and sets reimbursement levels. Deregulation of this market is evident in the fact that patients with pre-existing conditions may be excluded and that the amounts physicians charge is not regulated (Tanner, 2008:8). Co-payments are paid at point of service and patients are reimbursed through the government insurance or private insurance. Reimbursements are calculated as the amount reimbursed minus co-payments, which are based on the negotiated schedule between the health providers and the NHI Funds (Tanner, 2008:8).



### **4.2.3 National health insurance**

The NHI was coined by Thomas Clement Douglas out of his concern about the limitations that poor people had when in need of health care services. When Douglas was young, he had injured his knee and was afforded surgery only because he made himself available to undergo an experimental surgery (Hamilton, 2009). If this opportunity had not been presented to Douglas, he would not have received the medical attention he needed. The NHI model includes the provision of health services providers from private sector providers and payment comes from a government-run insurance programme that every citizen pays into (Reid, n.d.). Private-sector providers receive payment from the tax-funded system and all services are free at point of delivery. In general this model is cheaper and countries have considerable market power to negotiate lower prices (Reid, n.d.). There are three main goals of a NHI: to make provision for those who receive below minimum services, to have equal financial access to medical care or to have equal consumption of medical services (Feldstein, 1979:424). The services provided for in this scheme count only for medically necessary services. Private insurance is optional for those who can afford to top-up the services rendered by a NHI scheme. Top-up services include private hospital rooms, prescriptions, and child birth classes, amongst others (Reid, n.d.). Countries that use the NHI model include Ghana, Canada, and Taiwan.

#### **4.2.3.1 Ghana**

The NHI Scheme was established in 2004, following the promulgation of the NHI Act (650 of 2003). The health care system of Ghana was transformed with the establishment of the NHI Scheme (NHIS) in 2004 and the promulgation of the NHI Act (650 of 2003) (National Health Insurance Scheme, n.d.). In terms of addressing the needs of the poor, the NHI system was seen as a remedy to get away from the 'cash and carry' system that excluded many people from much-needed health care services. The NHI Act (NHIA) established the NHI Council (NHIC), tasked with monitoring and developing the operations of the NHIS as well as the management of NHI Fund (NHIF) (Wahab, 2008:6). The Act makes provision for the population to belong to any of three health insurance schemes, namely: District Mutual Health Insurance (DMHIS), Private Mutual Health Insurance Scheme (PMHIS), and Private Commercial Health Insurance Scheme (PCHIS). The DMHIS is located in every district and is subsidised by government. Wahab views this scheme as district orientated not-for-profit scheme. The PMHIS is also not-for-profit; the scheme is not injected with a subvention and may not have a district focus. Operating and establishing at PMHIS may be done by any group of persons, community, or

religious group in Ghana (Wahab, 2008:6). A PCHIS can be established with a district focus, on a for-profit basis and premiums are collected according to the “calculated risk of subscribers” (Wahab, 2008:6).

The NHIC is also responsible for:

- granting accreditation of health care providers;
- promoting health education in the country;
- managing the national health insurance fund;
- determining premiums;
- registering health care providers; and
- licensing and regulating DMIS (Wahab, 2008:6).

There are ten regions in total and the NHIS is also responsible for establishing regional offices to oversee the operations of the DMHIS. Formal and informal sector workers make contributions to health insurance. The formal sector workers make their contributions through Social Security and a National Health Insurance Trust Fund (McIntyre et al., 2008: A). The NHIS is financed by a 2.5% levy on VAT, mandatory payroll deductions of 2.5%, 17.5% Social Security and National Insurance Trust Fund and graduated premiums from the informal sector (Gyapong, Garshong, Akazili, Aikins, Agyepong and Nyonator, 2007:17). The Social Security and National Insurance Trust Fund is financed by 5% employee and 12.5% employer contributions. 44% of the population have health insurance cards, made available by government, the remainder pay for health services out-of-pocket (McIntyre et al., 2008: A).

The benefits package covers out-patient and in-patient services at accredited facilities, as well as community-based health planning services. This package differs from one DMHIS to another. Those who use out-of-pocket services in public and private facilities also receive a comprehensive package (McIntyre et al., 2008: A).

#### **4.2.3.2 Canada**

The Canadian Health Act of 1984 sets the framework for universal health care. The health system is characterised by local control, doctor autonomy and consumer choice. The health

system, also known as Medicare, is publicly financed but privately run. Providing universal coverage and care is free at point of use. The public health insurance system covers all medical care including psychiatric care in and out of hospital (Reid, 2009:126). All Canadian residents with a health care card have access to all the covered services and need not pay extra costs or user fees. French patients are free to select their own doctors (Birn & Nixon, 2010:517). According to Reid (2009:128), generally at no cost, acute illness, accident and emergency care are guaranteed in Canada's system, but if medical treatment is not urgently needed a waiting period will be required. The 10 provinces and three regions are the implementers of the health system, having the responsibility of "planning, financing and evaluating the provision of health care, negotiating salaries for health professionals and negotiating fees for physician services", according to Irvine, Ferguson and Cackett (2002:1). Provinces vary in size and fiscal capacity (Deber, 2003:21). As a result each province or region has a slightly different health insurance plan based on the extent of "coverage beyond medically necessary hospital and physician services" (Irvine, Ferguson & Cackett, 2002:1).

Through the Canadian Health Act, equity is ensured by penalising extra services. Basic principles to which provincial or regional plans must commit, even for financing and coverage, vary (Birn & Nixon, 2010:517). These principles, with the aim of providing a one-tiered service are:

- Public administration – provinces must administer and operate health plans on a non-profit basis.
- Comprehensiveness – provinces must provide medically necessary hospital and physician services.
- Universality – 100% of provincial residents are entitled to the health plan.
- Portability – protection for Canadians travelling outside their home province
- Accessibility – there should be reasonable access to services, not impeded by user charges or extra billing (Irvine, Ferguson & Cackett, 2002:1).

The Ministry of Health approves funds on an annual operating budget for each hospital in the provinces or regions. The budgetary allocations are based on past budgets, patient load, inflation, salary increases, case mix and capital expenditure needs. The budget functions as a measure for controlling costs, and hospital administrators and directors must stay within that framework. The provincial medical association and the Ministry of Health in a province negotiate

fees for physicians in the private sector; physicians are paid on a fee-for-services basis with a cap on their earnings (Birn & Nixon, 2010:517).

A variety of mechanisms are employed to fund two-thirds of the provinces' Medicare. An important source of funding is general revenues which include income and corporate taxes. Alberta, Ontario and British Columbia use premiums based on a sliding income scale (Birn & Nixon, 2010:517). Birn and Nixon (2010:517) state that "other provinces raise revenues through lotteries and sin taxes on alcohol and cigarettes". The Canada Health Transfer is a dedicated block grant that provinces must make use of. The fund contributes a third of health care expenditure. As noted by Deber (2003:21) provinces differ in size and fiscal capacity. Birn and Nixon (2010:518) mention that these differences are provided for in the federal government's equalisation payments, which are made to those provinces whose fiscal capacity falls below the 10 provincial median. \$Cdn 14 billion in equalisation transfers were made to six provinces in 2009/2010 for health and social spending (Birn & Nixon, 2010:518). Deber (2003:22) states that "Delivery in these regions is a considerable challenge because of the large number of small and isolated...communities". Deber (2003:22) further notes that the federal government cannot take the role of decision-maker although it can attempt to influence the direction of policy through supplying or withholding money or by setting out guidelines.

#### **4.2.3.3 Taiwan**

The Taiwanese health care system is divided between central and local level governments. The central government is responsible for policy-making, supervision and coordinating local level governments (Wu, n.d.:15). The National Health Insurance scheme covers the whole population, including legal residents since its inception in 1995. The 23 health bureaux function under county governments of which two are Taipei and Kaohsiung special municipalities.

The Bureau of National Health Insurance (BNHI) within the Health Department is responsible for administering NHI and contracting health care facilities (Li, 2006:34). The BNHI is responsible for implementing the NHI programme through six local branches, and the 25 city/county governments are responsible for the daily functioning of the system as well as the advancement of health within their respective areas (Li, 2006:34). According to Wu (n.d.:14), the Bureau of Medical Affairs within the Department of Health is responsible for regulating medical affairs, quality counselling for health care organisations, emergency rescue services, psychiatry and mental health services and human resources.

NHI premiums are shared between the individual, employer and the government. Individuals contribute 40%, the employer 33% and the government 27%. The premiums calculated for the unemployed are the average premium of all insured people. All citizens have to make co-payments for health services (Wu, n.d.:15), but there is a ceiling for low-income families that is legislated for (Li, 2006:35). Co-payments are estimated to range from 10% for in-patient care and 20% for out-patient care. For very poor individuals premiums are waived (Wen, Tsai & Chung, 2008:258).

Health service benefits include out-patient clinic visits, in-patient services, traditional Chinese medicinal treatment, delivering of babies, drug prescriptions, preventive care and immunisation for children, home care and rehabilitation services (Wu, n.d.:15). In Taiwan, there are public and private health care institutions. Private hospitals are divided into for-profit and non-profit, which can only be owned by physicians if licensed to do so but, in most cases, physicians are contracted by a hospital and cannot work anywhere else (Wu, n.d.:16). In general, patients have the freedom to choose what physicians they would like to see and are not restricted to specialists based on transferral (Wu, n.d.:16).

#### **4.2.4 Out-of-pocket model**

Hamilton (2009c) refers to the Out-of-pocket model as a non-system because a population has to pay out-of-pocket for health care. This system is used in the poorest countries. Although minimal health insurance exists, large portions of the population cannot receive health care because they do not have money. Countries such as Cambodia at 82.2%, Burundi at 82% and India at 82.1% have the highest percentages of population that pays out-of-pocket for health care (Hamilton, 2009c).

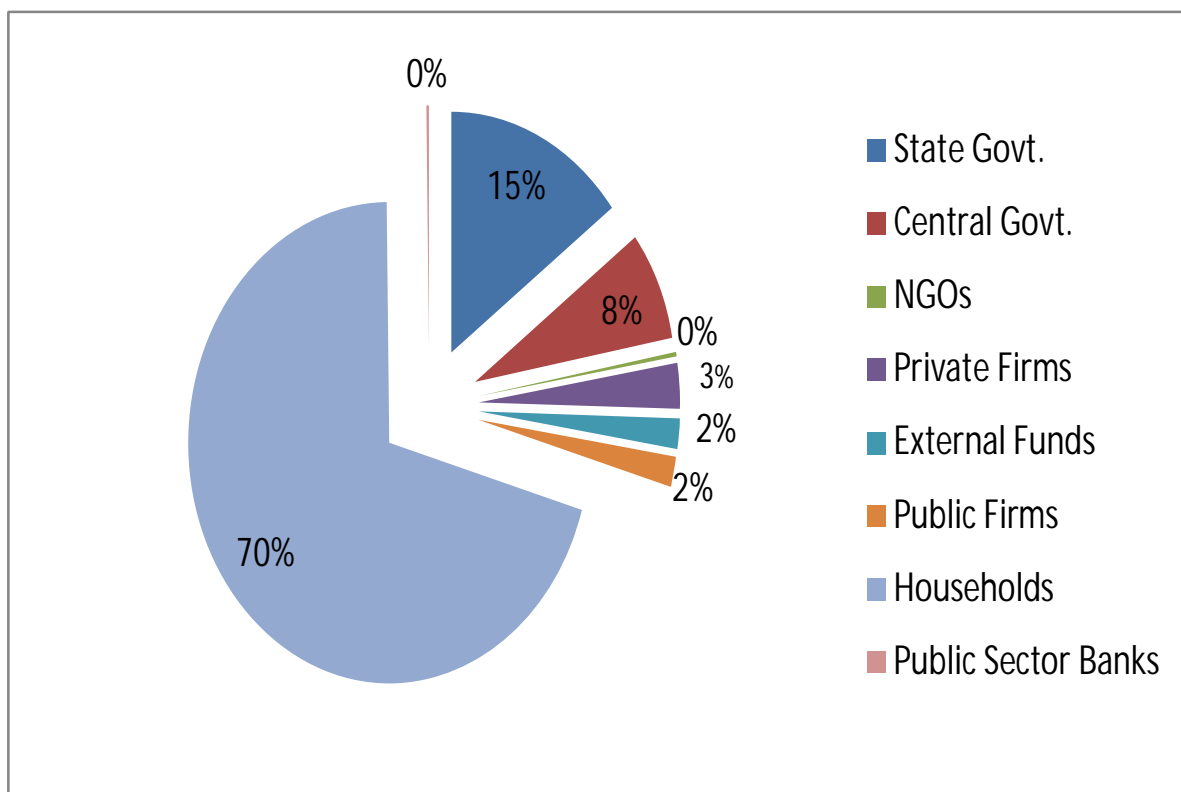
##### **4.2.4.1 Burundi**

Amongst African countries, Burundi is rated the country with the highest rate of out-of-pocket financing (Drouin, 2008:5). With 82% of the population paying for health care at the point of service delivery, a great threat is posed to the national health conditions of Burundians. Inequality plagues the health sector because people are unable to access health care because services are unaffordable. Philips, Ooms, Hageaves and Durrant (2004:634) state "this is because since February 2002, the Burundian government have implemented a policy of cost

recovery for health services”. This cost recovery system is aimed at allocating more resources to the health sector. At this time, 2002, the health sector was underfunded and the Ministry of Health was forced to “impose the burden of health care costs on the patient” (Philips, 2004:634). Walker (2010) suggests that years of civil war in Burundi have detrimental effects on the country’s economy. This may be a contributing factor to inadequate financial allocation to the health sector. Burundi is a country that has been severely affected by out-of-pocket health financing.

#### **4.2.4.2 India**

India is characterised by quality medical care to middle-class Indians and medical tourists, while the majority of the population have limited or no access to quality health care. From 2010 to 2015, the Indian population is projected to grow at a rate of 6%, making it the country with the highest growth rate for this period when compared to Brazil, China and Russia (Emerging market report, 2007:1). Apart from the expected growth, 11% of India’s population have health insurance while the remainder are left to use government facilities for which an out-of-pocket contribution is made (Emerging market report, 2007:7). The Indian health care system is dominated by out-of-pocket expenditures to which the projected increasing number of the poor population will fall victim (Figure 4.1).



**Figure 4.1:** Sources of funding in the health sector in India during 2001-02

Source: Rao, Selvaraju, Nagpal and Sakthivel (2008:240)

According to Rao, Nagpal, Selvaraju and Sakthivel (2008:239) “the poor pay disproportionately more on health care than the rich and access to health care is dependent on ability to pay”. When compared with other developing countries, a large share of India’s household expenditure is used for health care (Rao et al., 2008:240).

Health care is not solely financed out-of-pocket, health financing in India is sourced through:

- the tax-based public sector that comprises local, state and central governments, in addition to numerous autonomous public sector bodies;
- the private sector including the not-for-profit sector, organising and financing, directly or through insurance, the health care of their employees and target populations;
- households through out-of-pocket expenditures including user fees paid in public facilities;

- other insurance-social and community-based; and
- external financing through grants and loans.

The burden on households has increased in terms of nominal prices from Rs 364 in 1995-96 to Rs 905 in 2003-04 (Rao et al., 2008:240). Despite the growing population, increasing pressure on households, and a growing economy, health care infrastructure is in a poor condition in most parts of the country (Emerging market report, 2007:240). 15 of the 393 hospitals in India, roughly two-thirds were in the public domain in 2002, and were inefficiently and inadequately managed and staffed with poorly maintained medical equipment (Emerging market report, 2007:5). The impact of out-of-pocket financing is devastating to indigent Burundians and Indians and is a direct impediment to health equity.

#### **4.2.4.3 Cambodia**

The Cambodian health system is a decentralised system. The Ministry of Health has the sole responsibility for all health-related aspects including the development of strategic plans, implementation and evaluation of public health services (Ministry of Health, 2009). The Ministry of Health delegates separate roles and responsibilities to the provincial and local governments to ensure effective and efficient delivery of health services (Ministry of Health, 2009).

The traumas of Khmer Rouge's murderous reign had an effect on the Cambodian health system and it is a great challenge to the country. The country is still in recovery as decades of war destroyed hospitals and deepened poverty (Dugger, 2006). Thus, the population's health status is extremely low with an average life expectancy of 54.4 years. Cambodia remains one of the poorest countries in South-East Asia with an annual health expenditure of 0.5% of GDP (Soeter & Griffiths, 2003:75). Out-of-pocket expenditure amounts to 82%, constituting 11% of GDP. As result many households cannot afford health care (Soeter & Griffiths, 2003:75). According to Dugger (2006), two-thirds of public health spending is covered by international donors, who have constructed hundreds of hospitals and clinics over the years. There are also five non-governmental organisations operating segments of the health system, which include Health Net and Save the Children Australia (Dugger, 2006). The purpose of these organisations is to provide coverage to improve the performance of services like child immunisation, prenatal care and delivering babies at the health centres (Duggers, 2006). Cambodia's government recently expanded this approach to cover one in every 10 individuals. But this intervention has not been



enough to protect Cambodians from paying out-of-pocket for health services when most families live on less than a dollar a day. When sick, people often choose to use services from within the mostly unregulated market, such as, seeking self-treatment through purchasing drugs from informal drug sellers. When such remedies do not lead to recovery, patients seek traditional healers, traditional birth attendants, health centre nurses, midwives or private practitioners (Soeter & Griffiths, 2003:75).

### 4.3 Challenges of the direct and indirect models

The contributing mechanisms can further be classified into direct and indirect models as shown in Table 4.1.

**Table 4.1:** Direct and indirect models

Challenges: direct model	Challenges: Indirect model
Direct provisioning is related to funding and delivery of basic health care to low-income rural residents.	Relies mostly on the market to organise hospitals and clinics which compete for patients.
Services are tax-based and delivered at district hospitals, sub-district level health centres, staffed by physicians and nurses who cover 5000 people or more. Farmers also require health services and want services to be in close proximity. As a result district level services' staff exceeds demand.	Public trust model - government officials should have a strong sense of the needs of the public, and are challenged to confront providers who do not give quality services.
Suffers from inefficiency and low quality care. Public providers are funded by government; they are managed by bureaucratic rules rather than on the basis of quality of care, health outcomes and efficiency of operations. The services provided is not competitive and ends up disregarding the patients' needs and satisfaction, service providers are not challenged.	Surrogate model - keeping political interference to the minimum.

Source: Deduced from Hsiao (2007)

Under the direct model, one organisation can finance and provide health care (Hsiao, 2007:952). For example, the South African health system's organisation has a Health

Department which receives a budget from treasury that enables the functioning of all public health care institutions. The indirect model involves the separation of financing and provisioning of health services, and stemming from this model is the public trust and surrogate models. The public trust model is comprised of a government agency that acts as the purchaser and buys health services from competing public and private providers (Hsiao, 2007:952). Under the surrogate model the government is the health care funder “but delegates the purchasing function to private intermediaries” according to Hsiao (2007:952). Private intermediaries refer to general practitioners, community health boards, local cooperatives and private insurance companies (Hsiao, 2007:952).

Deduced from Hsiao’s direct and indirect models, the Beveridge model can be classified as a surrogate model. The Bismarck model can be associated with the direct model and the NHI model can be related to the public trust model.

#### **4.4 Health care reform**

From the discussion about the mechanisms contributing to an understanding of all the factors involved in a health system, the actual tools required to undertake a reform need to be chosen. To be able to adapt any of the health systems, and accomplish health sector reform there are important factors to consider. Health sector reform is described as a “sustained purposeful and fundamental change” (Berman & Bossert, 2000:2) in order to improve the efficiency, equity and effectiveness of the health sector. Reform should be a sustained ongoing process driven with purposeful changes that take account of the wider policy or political environment (World Health Organisation, n.d.). Known as ‘control knobs’, fundamental changes include financing, payment, organisation, regulation and consumer behaviour (World Health Organisation, n.d.). Countries in the African region that have undergone health reform are shown in Table 4.2.

**Table 4.2:** Examples of health sector reforms in the African region

COUNTRY	HEALTH SECTOR REFORM	INTENDED EFFECTS	MECHANISM (CONTROL KNOBS) THROUGH WHICH REFORM EXERTS EFFECT
Burkina Faso, Lesotho, Tanzania, Uganda, Zambia	Decentralisation of health services to sub-national levels	Better physical access to improved health services. Efficiency in resources use	Organisation of health services
Burkina Faso, Kenya, Uganda, Zimbabwe	Granting national and regional hospitals greater autonomy	Efficiency in resource use through improved accountability	Organisation of health services
Zambia	Institutional restructuring of government health care, creation of Central Board of Health	Efficiency in resource use through improved accountability	Organisation of health services. Financing of health services
Uganda, Ghana, Tanzania	Public-Private participation	Increased access to health care services through alternative providers	Organisation of health services
Benin, Burundi, Camroun, Burkina Faso, Ghana, Kenya, Lesotho, Mauritania, Mozambique, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia, Zimbabwe	User fees as a health financing option	Generate extra resources. Promote efficient use of these resources. Expenditure increment at health facility level	Financing of health services
Algeria, Benin, The Gambia, Guinea-Conakry, Mali	Community co-management and co-financing of essential drugs (Bamako Initiative)	Increased community participation. Generation of extra resources	Financing of health services
Burkina Faso, Ehtiopia, Guinea-Conakry, Rwanda	Community health insurance	Protecting the poor against medical expenses. Improving access for the poor to health care	Financing of health services

Source: World Health Organisation. n.d.

#### 4.4.1 Domains of action for health sector reform

When a country has a reform agenda, consideration should be given to five actors involved in the change process. In developing countries, the domains of action are finance requirements, payment requirements (costs), organisational requirements, prices or access, consumer pressures, technical feasibility efficiency and outcomes. In essence, all of these five actors should be in equilibrium to ensure that a knock-on effect is eliminated.

#### 4.4.2 Tools for developing health sector reform

The four tools that can be used when developing health sector reform as outlined by Berman (1995:25-26) are:

- Package of services

In order to determine a package of service cost-effectiveness and burden of disease analysis should be done.

- Financing

In terms of financing, National Health Accounts are important because they will reflect the trends and areas in need of financing. Financial simulation models must be established; preferably those that best address country-specific needs. When the simulation models are in place, an analysis of provider response should be undertaken. Changes in financing will not guarantee a positive response from providers, but the recommendation of the WHO to provide universal basic benefits package will not be in dispute. Reform of health financing should meet the need for equity, as outlined by McIntyre and Gilson (2005:7) below:

The mechanism should provide financial protection. – In other words, the mechanism used for financial equity should ensure access to health care services. Access should not be denied to a patient because of his/her inability to pay and households should not be threatened because the cost of health care is too high. In essence, a pre-payment system should be devised in order to ensure financial expenditure at the point of health service utilisation.

Health care financing contributions should be distributed according to ability-to-pay. – This means progressive health financing mechanisms should be prioritised. According to Ataguba and Akazili (2010:76) financing is progressive when it is distributed so that payments increase in proportion to increases in household income. This means the rich will pay more for health service than the poor. If the opposite occurs, it is referred to as regressive financing.

Cross-subsidies from the healthy to the ill and from the wealthy to the poor in the overall health system should be promoted. – This means that fragmentation between individual financing methods should be reduced and improvement of cross-subsidisation across financing methods should be addressed with financing mechanisms.

Mechanisms to ensure that financial resources are translated into universal access to health services should be put in place. This entails entitlement of health services via the funding mechanisms in place, clear and explicit benefits package which individuals are entitled to, purchasing of health services where 'value for money' is secured, and adequate physical access to services. With these key elements in mind, the discussion on funding mechanisms to address the priority aspects will serve as a tool for decision-making in this regard.

- Organisation of provision

The organisation of provision overall includes three aspects: cost analysis, considering a suitable management of information systems and service planning simulation models.

- Consumer demand

An economic analysis of demand for health care should be undertaken.

#### **4.5 Conclusion**

The analyses of different health care systems have broadened the scope of options when health care reform is formulated. Each model, as classified by Reid, has distinctive designs and various means to address a country's unique health care needs. Health care finances and management and all the other aspects stemming from these are major aspects of a health care system. Countries have implemented variations of the original health care models but it can still be noted that there are vulnerable groups that remain uncared for and those that can afford quality health care make hefty contributions. Universal health coverage, equity within the health care system, as well as accessibility, are the primary goals that countries want to achieve. These require well informed and well-calculated decisions when implementing change.

For South Africa's envisaging health reform, different avenues have been discussed in this chapter, but to ensure an overview of a range of possible reforms, a set of health-need criteria need to be established. Before the criteria is discussed, the next chapter will set out the methodological techniques used in this study, under which data was gathered, a criteria determined and results analysed.

## CHAPTER FIVE

### RESEARCH DESIGN AND METHODOLOGY

#### 5.1 Introduction

Research design and methodology is very important as it clearly defines how data have been collected and analysed. In this chapter, the qualitative research approach chosen for this study is discussed, as well as the research design pertaining to concept analysis. Furthermore, the data gathering technique, and the document study are explained; and data analysis and comparative analysis are also discussed. This chapter also contains a section reflecting upon the research experience and the lessons learnt from conducting the research in this manner.

The type of research undertaken does not typically fall under the qualitative method because of the phenomenon investigated. The qualitative research method serves as the platform for the study, as revealed in the following sections.

#### 5.2 The qualitative approach

Qualitative research is a form of scientific research. This approach shares characteristics of scientific research which generally consists of, as Mack, Woodsong, McQueen, Guest and Namey (2005:1) state, the following aspects:

- Seeking answers to a question.
- Systematically using a predefined set of procedures to answer the question.
- Collecting evidence.
- Producing findings that were not determined in advance.
- Producing findings that are applicable beyond the immediate boundaries of the study.

According to Shuttleworth (2008), the qualitative approach is more flexible when implementing different experimental techniques that encompass a variety of accepted methods and structures. Qualitative research has a strong emphasis on processes and meanings and not the examination or analysis of terms that are dependent on the quantity, amount, intensity or frequency (Denzin & Lincoln in Welmar, Kruger & Mitchell, 2005:8). The qualitative approach has been used in this research because it is the best way to achieve an understanding of all constructs and elements involved in public health on a large scale, specifically, contributing

mechanisms. All components of the research design and methodology will further motivate the selection of this approach. The advantages of the qualitative approach, as expressed by Shuttleworth (2008), are evident in the fact that this approach is useful when questions without a straightforward yes or no answer are posed. This method is not dependent on the sample size because designs like the case-study can provide useful information (Shuttleworth, 2008). When applied to the study of a suitable health care model for South Africa, the qualitative method provided the broad framework needed in which all crucial aspects could be reviewed.

### **5.3 Research design**

Research design is the blueprint of the path the researcher intends to follow when conducting the research (Babbie, Mouton, Vorster & Prozesky, 2009:74). More specifically related to this study Cresswell (in De Vos, Strydom, Fouche & Delport, 2005:268) defines qualitative research design as “the entire process of research from conceptualizing a problem, to writing the narrative”. In the planning of the study all the decisions the researcher makes are referred to as the design.

#### **5.3.1 Types of research design**

Various designs are selected based on their relevance to the purpose of the study, the nature of the research question and the skills of and resources available to the researcher (Fouche in De Vos et al., 2005:268-269). The different qualitative research designs are classified according to Maree (2007:72) as indicated below. The italicised design is the design used in this research.

**Table 5.1:** Qualitative research design

<p><i>Conceptual studies</i></p> <ul style="list-style-type: none"> <li>• <i>Conceptual analysis</i></li> <li>• Conceptual analytical studies</li> <li>• Conceptual cartography</li> <li>• Document analysis study</li> <li>• Critical hermeneutics</li> <li>• Fourth-generation evaluation studies</li> <li>• Grounded theory design (theory building)</li> </ul>
<p>Historical research</p> <ul style="list-style-type: none"> <li>• Historical research</li> <li>• Comparative research studies</li> <li>• Life history (e.g. the experiences of educators in exile)</li> <li>• Discourse analysis (mainly of texts and documents – secondary data sources)</li> <li>• Feminist studies (more geared towards critical feminism and not liberal feminism)</li> <li>• Some narrative designs (e.g. oral history)</li> </ul>
<p>Action research</p> <ul style="list-style-type: none"> <li>• Classical action research (aimed at improvement and change)</li> <li>• Participatory action research (more based on critical theory and aimed at empowerment)</li> </ul>
<p>Case study research</p> <ul style="list-style-type: none"> <li>• Case studies (single and multiple)</li> <li>• Developmental case study</li> <li>• Phenomenology (lived experience)</li> <li>• Clinical study</li> <li>• Evaluation research</li> </ul>
<p>Ethnography</p> <ul style="list-style-type: none"> <li>• Classical ethnography (aimed at understanding shared culture)</li> <li>• Auto-ethnography</li> <li>• Ethno-methodology (based on conversations)</li> <li>• Biographies (may also be historical)</li> </ul>
<p>Grounded theory</p> <ul style="list-style-type: none"> <li>• Classical grounded theory</li> <li>• Symbolic interactionism</li> </ul>

Source: Maree (2005:72)



### 5.3.2 Conceptual data analysis

According to Maree (2007:71), conceptual studies can be seen as “defining characteristics which are largely based on secondary sources that critically engage with the understanding of concepts and aims to add to our existing body of knowledge...”. Du Toit (in De Vos et al., 2005:425) state that “conceptual analysis is crucial for orienting oneself to one’s chosen field of research. At the most fundamental level, conceptual analysis is an attempt to become conversant with the basic tools of thinking and understanding, namely language, terms, ideas and concepts”. Conceptual analysis takes place right through the research process, but the focus is more drawn to the conceptualisation before writing-up. Conceptual analysis is important to this, and any other study, because the researcher enjoys the opportunity of being familiar with the important linguistic concepts that are related to, and shape, the research, and has good understanding of what the research is about and of how it can add to the existing body of knowledge.

Key articles that provide a rich conceptual foundation include:

- Reid, T. R. 2009. *The healing of America: the global quest for better, cheaper, and fairer health care*. New York: The Penguin Press
- McIntyre, D. 2007. *Learning from experience: health care financing in low and middle income countries*.  
[http://extranet.who.int/iris/bitstream/123456789/698/1/2940286531\\_eng.pdf](http://extranet.who.int/iris/bitstream/123456789/698/1/2940286531_eng.pdf)

[06 May 2010]

- World Health Organisation. 2000. *Health systems: improving performance*.  
[http://www.who.int/whr/2000/en/whr00\\_en.pdf](http://www.who.int/whr/2000/en/whr00_en.pdf) [28 May 2010]
- Van Rensburg, H. J. K. 2004. The history of health care in South Africa. In Van Rensburg, H. J. K. (ed.). *Health and health care in South Africa*. Pretoria: Van Schaik Publishers:52-103.

The documents introduce a wide range of conceptual linguistic aspects that, in turn, aid in the uncovering of many other related articles. Du Toit (in De Vos et al., 2005:424) explains that when using conceptual analysis the researcher attempts to comprehend objects, processes or phenomena in a linguistic manner. In the study of the most suitable health care model, many concepts and terms are introduced to create a broader scope of understanding of the phenomena under investigation. The introduction to the public health arena and the full interpretation of all the elements that impact on the suitability of the contributing mechanisms is funnelled, and finally focuses on four mechanisms.

## **5.4 Data gathering technique**

### **5.4.1 Document study**

There is a difference between using a document study as part of the literature review and as a data gathering strategy, according to Nieuwenhuis (2007:82). This research utilises a document study in its combined form; both as a literature and a data collection source. The motivation behind this technique is that the NHI scheme and the other contributing mechanisms under review have not yet been implemented in South Africa. Therefore, primary and secondary sources can be used to arrive at an expected result of the implementation of these contributing mechanisms. Sources range from media releases from the government, legislation and amendments to accommodate a change in the health system, relevant country experiences when implementing any one of the contributing mechanisms and internationally recognised work discussing all the elements of health systems. "Secondary data are information collected by individuals or agencies and institutions other than the researcher him- or herself" (Welmar et al., 2005:149). Secondary source utilisation outweighs that of primary sources in this study, it is useful to view the method and process followed to arrive at certain conclusions. The framework used for the process of secondary analysis by Strydom and Delport (in DeVos et al., 2005:320-322) is a close approximation to the process followed in this research.

- **Problem identification**

The research focus was sparked by the researcher's interest in topical national government issues that impact on the lives of South Africans. The 2008/2009 Budget speech by Trevor Manuel was pivotal in revealing government's priorities. Consequently, the NHI was mentioned, amongst other things, and it was intriguing. Thereafter, conceptualisation of the problem developed. An understanding of the primary health care services at the Wesfleur hospital in Atlantis, in the Cape Peninsula, aided in this purpose and drew the researcher closer to the real challenges that many South Africans face. The main question that emerged out of the challenges was: will a NHI scheme relieve the indigent from poor service delivery?

- **Formulation of research questions**

The initial research focus of solely testing the suitability of NHI in South Africa moved to testing what other contributing mechanisms could address the current health care challenges. By comparing information provided in the literature, the contributing mechanisms of different health systems were discussed concurrently and the health system that best addressed the health

care needs of South Africa was proposed as the best option. Against this background, the research questions were developed accordingly and the nature and scope of the research was realised through a combination of approaches. The approaches range from a full report, abbreviated reports, extended reports and reports that focus on the subthemes of the main theme, as Strydom and Delpont (2005) list them.

- **The pilot study**

A formal pilot study, as discussed by Strydom and Delpont (2005) was not executed. An *informal* pilot study was done by observing health service delivery at the Wesfluer Hospital, as well as by having discussions with a random selection of people (including neighbours, family and friends) concerning their views on current health services. This was done with the purpose of testing the feasibility of a full-scale study (Van Teijlingen & Hundley, 2001) in health care and of gaining an understanding of the national challenges as a lens for comparisons.

- **Reprocessing the data**

In terms of processing data, it is useful to continually reflect on the conceptual framework for the research. Data are reviewed with regard to their relevance to the topic discussed. Delpont (in De Vos et al., 2005:321) suggests that the following questions be kept in mind:

- What was the purpose of the data collection in the original study?
- Who was responsible for the data collection?
- Which sampling frame was used?
- How consistently did the original researcher handle the data collection?
- Is the investigation still relevant at the present time?

Of particular importance to this study is the relevance any investigation has to the present. The researcher always ensures that where possible, all information is current and, prefers to consult documents that are not be older than 10 years old.

- **Analysing and interpreting the data**

In this phase, the researcher can compare the processed data to ensure that validity and reliability has been established. In relation to this investigation, this phase of the document study is related to the gathering of data in the analysis of health care models of different countries.

- **Report writing**

In this last phase, the writing-up phase, the researcher collates all the findings and presents them as a proper scientific report. Strydom and Delpont's (2005) are of the view that the transferability and verifiability of a research report cannot be evaluated differently.

#### **5.4.2 Reliability and validity of document study**

In terms of understanding reliability in qualitative research, Golafshani (2003:601) believes that it is related to testing the quality of such a study. Reliability serves a dual purpose of explaining quantitative studies and generating understanding in qualitative studies. "The differences in purposes of evaluating the quality of studies in qualitative and quantitative research are one of the reasons that the concept of reliability is irrelevant in qualitative research" (Golafshani, 2003:601). This means that reliability in the qualitative paradigm is employed on the basis of testing quality in order to solicit understanding. In Golafshani's work, validity is used as a measure of having a qualifying check for research. Researchers have developed their own terms for validity, which they deem more appropriate such as quality, rigour and trustworthiness (Golafshani, 2003:602).

De Vos et al., (2005:317) use the terms 'validity' and 'reliability' in their standard form, but the underlying aspects related to qualitative research are also considered in this investigation. To ensure validity and reliability in this study, people with knowledge in the public health field were interviewed and the documents obtained were compared against their expertise to test whether the information was influenced or not by author prejudice (in De Vos et al., 2005:317). The sources were also checked against similar documents, more specifically, findings were compared against each other and, as Bailey (in De Vos et al., 2005:318) rightly puts it, emphasis was placed on inter-analysis reliability. For instance, in the process of determining the criteria to test the suitability of contributing models, three secondary documents were compared: the World Bank, the World Health report and the report of McIntyre in 2007.

### **5.5 Qualitative data analysis**

#### **5.5.1 Comparative analysis**

Henn, Weinstein and Foard (2006:60) state that "at an analytical level, we make comparisons between the influence of variables from questionnaire results, or accounts in interview transcripts, or documentary sources and field notes on observational settings. On a more

general level, we compare within societies (inter-societal) and between societies (intra-societal comparison)". Henn, Weinstein and Foard's statement incorporate the motivation for using comparative data collection technique in this study.

A lens or keyhole comparison was used in this study (Walk, 1998). This means that the challenges in the health care sector, and the health care structure were used as a lens through which various solutions (contributing mechanisms) were analysed. According to Walk (1998), there are two sides to the analysis, known as A and B. In this instance, A took the form of the analysis of the health system and health sector challenges and B reflects the contributing mechanisms. In combination with B, a financial health sector reform criterion is used to measure the suitability of each contributing mechanism. The criteria and motivation for its selection is discussed in the next chapter.

The motivation for using this approach lies in the nature of the phenomenon under investigation, the NHI, which is, in fact, the analysis of policy. Because there has not been any reform to the health system, the effects cannot be evaluated, but the current health system aided in creating a platform from which to analyse any proposed changes and to project expected outcomes in the existing health sector.

## **5.6 Data collection challenges and lessons: the researcher perspective**

Strydom and Delpont (in De Vos et al., 2006:317) warn against there being a time lag between when documents were published and the time, and hence relevance they will have in, a particular piece of research. Careful selection of sources has ensured the use of recently published sources – in the majority of cases – in order to make the research findings applicable to South Africa today. Complexity and finding original sources of information, as suggested by Strydom and Delpont (2005) best reflect challenges that emerged in the course of the study.

At first glance, the concept under review and the degree of complexity of the health system under investigation was not apparent. As the study progressed, more constructs were introduced to the researcher that were somewhat challenging. The lesson learnt was that through reviewing a variety of information more clarity was gained. The greatest challenge was making a transition and a valid connection between media releases and journal articles. Here it was learnt that media releases may introduce the researcher to the key words needed to make a journal article search. To obtain a source, it must be borne in mind that a key document,

preferably a journal article, reference or list of bibliography, can be used to discover many other sources that would not have been available in a normal search. Most of the primary sources in most secondary sources can be traced.

## **5.7 Conclusion**

The unique design and methodology of this study was discussed and brought more insight into what comparative analysis means with regard to the topic. The researcher reached a renewed appreciation for concept analysis and document study throughout the investigation especially the attention to detail, in terms of precautions that were required for each approach.

The next chapter bring together all the findings and challenges discussed throughout the research and criteria will be identified for further analysis of the suitability of the four health care models in South Africa.

## **CHAPTER SIX**

### **FINDINGS AND ANALYSIS OF THE CONTRIBUTING MECHANISMS WITHIN HEALTH CARE SYSTEMS**

#### **6.1 Introduction**

The contributing mechanisms evaluated in this study are partially implemented in the South African context. The different contributing mechanisms distinguish the four health care models from each other, and are, therefore, the common denominators and focus of this analysis. The purpose of this chapter is to make a forecast of the possible outcomes that the different contributing mechanisms will have in the South African health care context.

The anticipated changes to the South African health system are known as health sector reform (HSR). HSR will guide the selection of a criterion and provide clarity in terms of the factors involved in the evaluation of health reform. Apart from Kenya, the five different categories of criteria discussed have already been implemented in other parts of the world. The criterion selected in this chapter reflects the extent to which financing mechanisms will best address the health needs of South Africa. The principles behind the definitions of HSRs as mentioned in Chapter 4 provide the basic guidelines for assessing the contributing mechanisms. Many ways exist to evaluate a HSR, as reviewed in this chapter, but criteria used by McIntyre (2007) will be applied in this study mainly because these criteria have been used in a previous assessment in South Africa and other developing countries. An evaluation of the contributing mechanisms, as tested against the determined criteria, is also included and tabulated in this chapter.

#### **6.2 Identification of criteria for analysis**

Countries follow different approaches when making a HSR. The definition of HSR is the premise on which all health reforms should be built. The standard definition of HSR is a “sustainable, purposeful and fundamental change in order to improve the efficiency, equity, and effectiveness of the health sector” (Berman & Bossert, 2000:2). Every HSR should be sustainable in fulfilling its purpose, whether it is a big “R” or small “r” reform, and these reforms should address improvement of efficiency, equity and effectiveness of the health sector (World Health Organisation, n.d.:4). In terms of the sustainability of a reform, equity, efficiency, and effectiveness are prerequisites for a HSR. This is based on the evaluation criteria discussed and

outlined in this chapter. These aspects form the premise on which all variations of HSR evaluation is built.

HSR mechanisms can exert change, known as control knobs and include financing, payment organisation and consumer behaviour (World Health Organisation, n.d.:11). The revamping of a health system would be considered as big “R” reforms because all the control knob factors are included in such a reform. In the HSR process, two main phases must be in place before the implementation of reform: the first phase, conceptual framework for health sector reform analysis and, after implementation; the indicators for monitoring and evaluating HSR. To evaluate HSR, the criteria or main components emanating from the HSR definition are sustainability, equity, effectiveness, efficiency and quality. Emanating from this standard definition, more criteria are identified. The following, although not an exhaustive group of categories, reveals that in every criterion, two or three elements of the definition are evident.

### **6.2.1 Criteria based on health sector objectives**

The assessment of reforms is based on health sector objectives such as “efficiency, equity, sustainability, etc.” as stated by McPake and Kutzin (1995:4). According to the WHO (2000:24) “systems are often charged to be affordable, equitable, accessible, sustainable, of good quality and perhaps to have many other virtues as well”.

### **6.2.2 Criteria on an international scale**

Schoeman (2007:137) sheds light on the international best practice framework, namely: effectiveness, efficiency, economy and equity (also known as the 4Es) when evaluating health systems in terms of health, social and financial policies. The criteria used by Schoeman (2007:138) are primarily aimed at public-private partnerships (PPP) on national and international levels. Some aspects such as financial assistance to a government from a PPP intervention, international and intersectoral relations, and the role and effects of players in the government are discussed by Schoeman.

### **6.2.3 Criteria used in OECD countries**

The evaluation of HSRs in Organisation of Economic Co-operation and Development (OECD) countries covers changes over several decades and targets issues such as access, cost-control and the crippling effects of spending restrictions. According to Docteur and Oxley (2003:4) health reform is assessed based on its impact on the following policy goals:



- Ensuring access to needed health-care services.
- Improving the quality of health care and its outcomes.
- Allocating an appropriate level of public sector and economic-wide resources to health care (macroeconomic efficiency).
- Ensuring that services are provided in a cost-efficient and cost-effective manner (microeconomic efficiency).

#### **6.2.4 Criteria for African countries**

The African continent has over the last two decades addressed HSR issues pertaining to narrowing the gap that exists in access, equity, effectiveness, efficiency and sustainability (Barry, Diarra-Nama, Kirigia, Bakeera and Somanje, 2009:S25). The WHO provides guidelines on monitoring and evaluating health reforms in the African region. It was found that “...evaluating a HSR is about assessing the extent to which the reforms have helped to improve levels of equity, effectiveness, quality and sustainability” (World Health Organisation, n.d.:19). This is related to any kind of reform to the health system. Kenya assessed the expected performance of the National Health Insurance Fund based on a conceptual framework that includes health financing targets such as resource generation, optimal resource use, and financial accessibility of health services for all (Carrin, James, Adelhardt et al.,2007:130-131).

#### **6.2.5 Criteria for financial health sector reform**

More specifically directed at financing, and the focus of this study, the WHO (1993:8) criteria for assessing changes in financing includes level of funding, efficiency, equity, viability, and health impact. McIntyre’s (2007:5-6) criteria for assessing health care financing mechanisms are feasibility, equity, efficiency and sustainability. The same framework of criteria was used in the World Bank report to assess health financing policies and evaluate their functions in an equitable, efficient, and financially sustainable manner (Gottret & Schneiber, 2006:2). In the discussion on health financing mechanisms, feasibility is also mentioned (Gottret & Schneiber, 2006:81).

From the above it can be seen that there are many criteria used for different HSR assessments. The criteria for financial HSR are more appropriate for this study because contributing mechanisms are the research focus. McIntyre’s (2007) criteria are selected on the basis that they are more comprehensive and clearly outlined. The same evaluation was used to test all

the contributing mechanisms. The criteria have elements that are consistent with the HSR definition. It is in accordance with the World Bank report of 2006, the 2000 World Health Organisation report on health systems and, as stated by McIntyre (2007:7), the framework for assessing financing mechanisms “is based on the key functions that a mechanism must perform to be accepted as a candidate for adoption by a country or community”. The key functions are collection, pooling, purchasing, and provisioning of funds (Kutzin, 2001:174).

### **6.3 Components of the criteria**

McIntyre’s (2007) criteria include the following components: feasibility, equity, efficiency and sustainability. Each aspect is briefly discussed.

#### **6.3.1 Feasibility**

Feasibility, which means “the likeliness of it being beneficial”, will be tested according to the following questions.

- Are the stakeholders likely to support or oppose a given financing mechanism?
- Is there enough administrative capacity to ensure successful implementation?

#### **6.3.2 Equity**

Equity refers to the individual’s contribution in accordance with the ability to pay and the provision for cross-subsidies from rich to poor. The purpose of cross-subsidies is to ensure that families are not impoverished because the cost of health care is high. This is based on the rationale that the cost burden should not only fall on the individual, but should be spread across the household. Many families have taken loans and are weighed down by the burden of interest payments, thus jeopardising the livelihoods of the whole household. An equitable system provides for progressive funding mechanisms where the high-income groups contribute a higher percentage of their income than the low-income groups.

#### **6.3.3 Efficiency**

When a financing mechanism is efficient, a large percentage of the funds generated from whatever source are used well, and there is very little waste. These funds should be allocated to services dealing with frequently occurring types of ill-health and fundamental services. Resources should be assigned to the maximum number of fundamental services whilst minimising the cost but not compromising the quality of care (Donaldson in McIntyre, 2007:6).

### **6.3.4 Sustainability**

Sustainability is defined “as the capacity of the health system to function effectively over time with minimum external input” (LaFond in McPake & Kutzin, 1995:40). The sustainability of a contributing mechanism refers to how stable it is and its potential to generate revenue. Sustainability in this regard is reflected in the maintenance of financing levels in the long term as well as the expansion of funding over a period of time.

Changes to financing systems are rarely discrete; they take place in stages, and the progress of any implementation can vary in different regions or facilities within a country (WHO, 1993:9). In the context of this research, changes or reforms to the health system of South Africa will have a direct impact on the financing mechanisms. Discussing the evaluating criteria for the four contributing mechanisms is imperative to determine the most suitable mechanism for South Africa.

### **6.4 Evaluating the four models in terms of their common denominator, contributory mechanisms**

There is a need to clarify how the health care models, in terms of sources of funding, translate to financing mechanisms. The models, as discussed in Chapter 4, differ. The Beveridge model is government-funded, but private options are available. The government provides hospitals, clinics, and doctors to all citizens. Under the Beveridge model, the government is the sole payer and has control over what doctors can do and what they can charge (Frontline, 2009). Citizens do not pay bills, but tax contributions which, according to Hamilton, are 17.5% of sales tax.

The Bismarck model is run largely by private hospital doctors and insurance plans. People resident in countries using the Bismarck model must have some form of insurance. The insurance companies work on a non-profit basis and are bound by law to enrol people with pre-existing health conditions. The Bismarck system provides for short waits, quality care and low costs (Hamilton, 2009b). An insurance system is used in this model; the insurers are called “sickness funds”. The funds are usually jointly financed by employees and employers through payroll deductions (Tetrahedron, n.d.). This is a multi-payer model, but tight government regulations ensure cost-control, similar to that provided by the single-payer Beveridge model.

The NHI model includes the provision of health services from private sector providers and payment comes from a government-run insurance programme that every citizen pays into (Reid,

n.d.). Hamilton (2009c) refers to the Out-of-pocket model as a non-system because the population has to pay out-of-pocket for health care. This system is used in the poorest countries. Although minimal health insurance exists, large portions of the population cannot receive health care because they do not have money.

Each of the health care models has its own contribution mechanisms, as discussed above in Chapter 4.

- Beveridge model – government funding
- Out-of-pocket – out-of-pocket model
- Bismarck model – health insurance (tax-based system, mandatory insurance)
- NHI – health insurance (mandatory insurance – national health insurance)

According to McIntyre's (2007:3-11) classification of financing mechanisms, the Bismarck and Beveridge models fall under government funding, while health insurance is related to voluntary and mandatory insurance.

## **6.5 Analysis and evaluation of results**

### **6.5.1 Analysis**

Table 6.1 shows the suitability of the contributing mechanisms for the four health care models. 'Yes' or 'no' are tabulated and factors substantiating these claims are explained. The number allocated to each contributing mechanism is used to indicate the results sequence in the discussion of each contributing mechanism.

**Table 6.1:** Criteria and results of financial health sector reform

Payment mechanisms	Criteria			
	Feasible	Equitable	Efficient	Sustainable
Voluntary health insurance	No	No	No	No
National health insurance	Yes	Yes	Yes	Yes
Out-of-pocket payments	No	No	No	No
Tax-based system	Yes	Yes	Yes	Yes

### 6.5.2 Voluntary health insurance

Voluntary health insurance (VHI) is not really feasible for the whole population. The South African private sector currently suffers from spiralling costs. As a result, cream-skimming and adverse selection takes place amongst the health insurance schemes. This mechanism has, over the years, been advantageous to those who can afford the cost of health care. In principle, the main notion of a prepayment system is something that can guarantee health care to the whole population. Because of the high cost associated with VHI or private health care, almost 80% of the South African population will not be able to maintain the payments as 24.3% are unemployed (Pan African News, 2009). The total number of poor is 942 731 people (Municipal outreach project, 2009) meaning, the financial resources needed for VHI will most definitely be out of reach for this group. Administrative costs are amongst the factors contributing to the spiralling costs. Thus VHI cannot be viewed as feasible in the South African context.

In terms of equity in the medical scheme environment, there are challenges due to a lack of cross-subsidisation and risk-pooling amongst and between the schemes. If the 84% of the population dependent on the public system were to receive health care financed through this mechanism, many people would indeed become impoverished as costs are consistently increasing.

Services in this sector are most frequently drawn from specialist doctors and hospital services. Providers are reimbursed on a fee-for-service basis, thus encouraging providers to create demand – patients are treated over a longer period of time than needed. This does not mean

that patients' real health care needs are met (McIntyre, 2010). Voluntary health insurance functions on a profit basis. Apart from the patient fees, costs are incurred in order for the schemes to make a profit. There are more human resources and a declining or stagnant membership; new members are unable to get on board because of the cost.

Notably, the main aspects to be considered when efficiency is tested are: resource allocation to fundamental and chronic health services, maximising the number of fundamental services, and minimising costs without compromising quality of care. In terms of addressing these aspects against the private sector setting, there are too many limitations for the mechanism to be beneficial for the population's health needs. Thus, the mechanism cannot be regarded as efficient.

The focal point of sustainability centres on the maintenance of financing levels. Understandably, there is a relationship between the provider and the purchaser of a service, as discussed in the Kutzin framework. For this reason, it can be said that maintenance of the financing levels should come from both sides. The question that arises is: will a purchaser/patient have the financial ability to ensure health care coverage on a long-term basis, given the fact that due to the cost spiral, the provider can be pressured to increase service costs accordingly? In essence, will financing mechanisms be maintained?

Financing levels cannot be maintained because of the cost spiral which, in the case of South Africa, is above inflation. With reference to the identification of the problems in South Africa, the weak regulatory framework in which the medical schemes function is not conducive to the growth of a risk pool because of the consequential cost burden and the decline of benefits.

### **6.5.3 National health insurance**

The response of General Practitioners to the introduction of NHI in South Africa, according to research conducted in 1995, indicates that 63.4% approved or strongly approved of the proposed introduction (Blecher, Bachman & McIntyre, 1995:848).

As discussed in Chapter 3, the whole population will be covered (McIntyre, 2007:xii) Carrin, James and Evans (2005:6) are of the opinion that more efficient services are available under this contributing mechanism. Based on the coverage provided, the acceptability and availability of efficient services, this mechanism is feasible.

Individuals contribute to a pooled fund and at any given time the healthy help to pay for the cost of those who are ill. The risk of unexpected high health care costs are being incurred by those falling ill, is shared amongst the members (McIntyre & Van den Heever, 2007:73). In other words, this contributing mechanism provides that the three risk pools, as discussed in Chapter 3, will be merged and the risk will be shared amongst the contributors. This enables patients who would have been cream-skimmed, based on demographic and other factors, to maintain membership of the NHI.

Related to administrative capacity, it is envisaged that a new NHI and administration unit will be created to manage the estimated R200 billion implementation costs (Bateman, 2009:562). Deduced from Bateman's findings, the needed administrative capacity will be catered for. Caution must be exercised in the process of implementing NHI; it cannot be implemented overnight because it is not the panacea to all the health sector problems in South Africa.

The core of the NHI contribution mechanism is captured in mandatory coverage of the whole population as well as the shared cost burden amongst the members. People who are able to make a contribution must do so, and those who cannot are exempt, but make indirect contributions through value-added tax. The main purpose of equity in a contributing mechanism is expressed in NHI. Therefore, it is evident that this mechanism is equitable in the South African context against the background sketched out in Chapter 3.

Using this contributing mechanism, there should be a benefits package that will be included in the scheme. For example, generally, Ghana's benefit package includes out-patient and in-patient services (McIntyre et al., 2008:A). If services are clearly defined (Carrin et al., 2005:6), resources can be allocated accordingly. In terms of minimising the cost, government negotiates and bargains on behalf of the whole scheme, thus ensuring lower provider prices.

Contributors under this mechanism are more entitled to the health care services because they make a direct payment and these monies can be used for the sole purpose of ensuring health coverage when needed (McIntyre, 2007:21). This sense of entitlement is not evident under the tax-based system because government has many commitments and health care might not be a top priority (McIntyre, 2007:21). Thus, according to McIntyre, the health insurance mechanism has the potential to be sustainable. The sustainability of this mechanism is not only evident in the direct injection of money into health care, but also the role government plays in terms of bargaining to keep health-related cost increases to a minimum. In the South African situation,

this can be interpreted as the refocus of financial expenditure into one sector and the subsidisation of the indigent to receive access to health services. As defined by McPake and Kutzin (1995), sustainability is connected to effective financing of a health system without using external sources such as donors, loans, and grants. Derived from McIntyre's findings, donor funding is not a reliable source for sustainable funding (McIntyre, 2007:47). The NHI does not only make use of employers' and employees' contributions but also tax. To a certain extent, the unemployed will contribute towards their subsidies through VAT. Further, the NHI does not rely on the use of external sources. All these factors read to a belief that it is sustainable.

#### **6.5.4 Out-of-pocket payments**

Members of the population likely to oppose this payment mechanism are those unable to carry the cost of out-of-pocket payments. Carrin, Mathauer, Xu and Evans (2008:857) agree that "many others might forego only some services, or suffer less severe financial consequences imposed by user charges, but people everywhere, at all income levels, seek protection from the financial risks associated with ill health". In the event that out-of-pocket payments shock a household, a regressive form of financing is implemented and the financial expenditure exceeds the income increases. People may be forced to use savings, sell assets, borrow money from friends and family or make loans (Leive & Xu, 2008:849). The unemployment rate in South Africa increased to 24.3% in 2008 from 23.5% in 2009. This figure also represents an increase from 3.87 million people to 4.18 million in early 2009 (Seria & Cohen, 2009). The statistics suggest that people can become impoverished because of seeking health care (McIntyre et al., 2008:872). This means that the out-of-pocket model is not feasible.

Equity requires health care coverage for the whole population, McIntyre states that "an equitable health care financing system will, therefore, involve cross-subsidies from the rich to the poor and from the healthy to the ill" (2007:5). The fundamental aspect of the out-of-pocket mechanism is that health care is provided based on ability to pay. When unemployment is high, more people will be unable to receive health care. According to statistics, nearly 70% of the formally employed population in South Africa earn less than R2 500 per month (Mutymbizi, n.d.:6). This means that out-of-pocket payments cannot be maintained over a long period of time, having devastating effects on the accessibility to needed services. It is estimated that 1.3 billion of the world's low-income populations "face financial catastrophe... 44 million households suffer severe financial hardship" and 25% of the world's population is forced to pay for the use of health care services on an out-of-pocket basis (Carrin et al., 2008:879). Out-of-pocket



payments in South Africa are largely founded on co-payments to medical schemes (Mutymbizi, n.d.:6). The co-payments are made by 21.1% of the population for primary care. Hospital care is very expensive, so public hospitals are preferred. Supported by the evidence, this contributing mechanism is highly inequitable as the health care needs of the whole population will not be addressed.

Under the out-of-pocket system, the chances of generating more money from a population that already is 86% dependent on public services because of the cost element are not favourable.

Health care costs cannot be sustained or expanded over a period of time, because more pressure will be placed on the consumer and the state (as subsidiser) to raise payments in terms of long-term financing.

#### **6.5.5 Tax-based mechanism**

This financing mechanism is already implemented in South Africa. Therefore, it might, in fact, be a question of whether the stakeholders will support levy increases or oppose government priority budgetary allocations that would accompany the full implementation of this financing mechanism. Like most insurance schemes, the tax-based system works on a prepayment system that is levied countrywide unlike the out-of-pocket mechanisms (Carrin, Evans & Xu, 2007:652). According to Gottret and Schneiber (2006:76), a tax based national health systems ought to perform well because the risk of the entire population is pooled and financed through budgetary allocations on a prepayment basis. There might be resistance from the stakeholders, because under this model there is no guarantee that an increase in tax will result in an effective tax-based system and the populace perception of state rendered service delivery can become more negative. Based on these findings and response of the population in terms of stakeholders support and administration, a tax based system could be feasible if managed well.

As stated by Carrin et al. (2008:858), contributions are made through taxes and those with low incomes could be exempt. This is the scenario in South Africa. Revenue is the primary source of financing that secures health care on a prepayment basis. "Prepayments are compulsory and generally set according to income. All people make payments (through taxes or through contributions) whether they are sick or not, although people on very low income or other vulnerable groups might be exempt" (Carrin et al., 2008:858). It can be said that the government funding mechanism is equitable because people are not excluded from health care based on their ability to pay.

The current situation in South Africa in terms of resource allocation to high cost-health needs is provided for and government has started rolling out programmes in response to the case brought to court by the Treatment Action Campaign (TAC) (Hassim et al., 2007:40-41). The High Court was in favour of TAC's argument that there was a link between HIV/ and AIDS, that correct information should be shared about the disease and that antiretroviral medicines be made available in all public facilities (Hassim et al, 2007:40-41). Basis services are provided at the primary health care level (Hassim et al, 2007:101). The financial expenditure in the South African tax-based system is evidently lower than that of private intermediaries (McIntyre & Theide, 2007:36). Services are available targeting the high ill-health services but the quality of services is many times compromised because of the large service base of health care. A large amount of funds are generated under this mechanism but government's many commitments can cause detouring of resources to other services. Above all these challenges, from the South African experience, this mechanism can be viewed as efficient in terms of resources allocated to high cost-health and fundamental services.

This mechanism is sustainable because more resources are pooled for health care. Under the mechanism, financing can be maintained because of the compulsory nature of the tax-based system. Future financial expansion can also be envisaged; the South African government has declared to commit 16% of government funding to health care.

## **6.6 Conclusion**

This chapter has dissected the four contributing mechanisms in terms of the health care models (Beveridge, Bismarck, NHI and Out-of-pocket) and matched them to South African health care challenges. The analysis, as discussed and tabulated, reflects the advantages and disadvantages of the different health care models. The findings reveal that the prepayment mechanisms, tax-based and insurance systems are most favourable, but the out-of-pocket system that poses a threat to the continued financial viability of households, is not recommended. With premises of an argument leading to a conclusive statement, the NHI mechanism and the tax-based, Beveridge model are more applicable in the South African context. Hsiao's (2007) dissection of the two mechanisms further refines the analysis; the NHI or the indirect model, as discussed in Chapter 4, is the most advantageous.

## CHAPTER SEVEN

### CONCLUSIONS AND RECOMMENDATIONS

Health care reform is a necessary debate in South Africa considering the challenges to achieving, and the barriers that hinder the realisation of equitable health care access to all. The purpose of this study was to determine which health care model will best suit South Africa. The common thread that is evident throughout the analysis of the health models is that most governments are seeking to provide universal health care coverage and to keep out-of-pocket payments to a minimum. France requires co-payments for some services to ensure that consumers do not overspend even though the government or private insurance make reimbursements. A close examination of the models was made in terms of the contributing mechanisms.

The financial aspects of the different models were analysed, with a focus on the contributing mechanisms. Throughout the discussion aimed at finding the most suitable contributing model that would assist in finding the best health care model, the four key aspects of equity, feasibility, efficiency and sustainability, were addressed when the criteria were tested. Features consistent in government-funded, tax-funded and the NHI systems are summarised as follows:

- Universalism – ensuring that the whole population is covered and enjoy access to health care on an equal basis.
- Prepayment for health care – paying in advance of an illness or any catastrophic accident, people are insured against impoverishment and financial burden. Prepayments are made through tax deductions and insurance premiums.
- Minimum out-of-pocket spending – governments protect the population, especially the poor, against increased pressure on households to obtain loans for health services and receiving such services based on ability to pay.
- Health systems – some countries have the same health system throughout the country while in others it varies between provinces in relation to the population size and the fiscal capacity. An example is Canada. All health systems are decentralised in a two-or three-tiered model.
- Health care providers – this is regarded as the greatest difference between the tax-funded and NHI models. Health care is either provided by the state, as in the tax-funded system, or by the public and private institutions in the NHI model.

- Benefits package – a standard benefits package is available to the whole population to ensure universal health care coverage. Each country has a different benefits package; in other words, those services a country deems to constitute basic health care services, are provided.
- Role of private insurance – countries that use these two systems have private insurance as a supplementary option in addition to the basic coverage provided or legislated for by government. This is not the case in Spain because a two-tiered system is developing. The population in the countries discussed under the two suitable systems, cannot opt out of government basic coverage.
- Health care expenditure – an increasing amount of money is spent on health care. Comparing South Africa's expenditure and that of Canada, there are similarities, but in terms of the effectiveness of the health system South Africa needs to improve.

From the analysis of the health care models in terms of financial contributing models, the Beveridge (government-or tax-funded systems) and the NHI models are the best suited for South Africa. South Africa needs a system that incorporates all these aspects in the current or any future health care reforms that are made, in order to ensure that health care is provided equitably.

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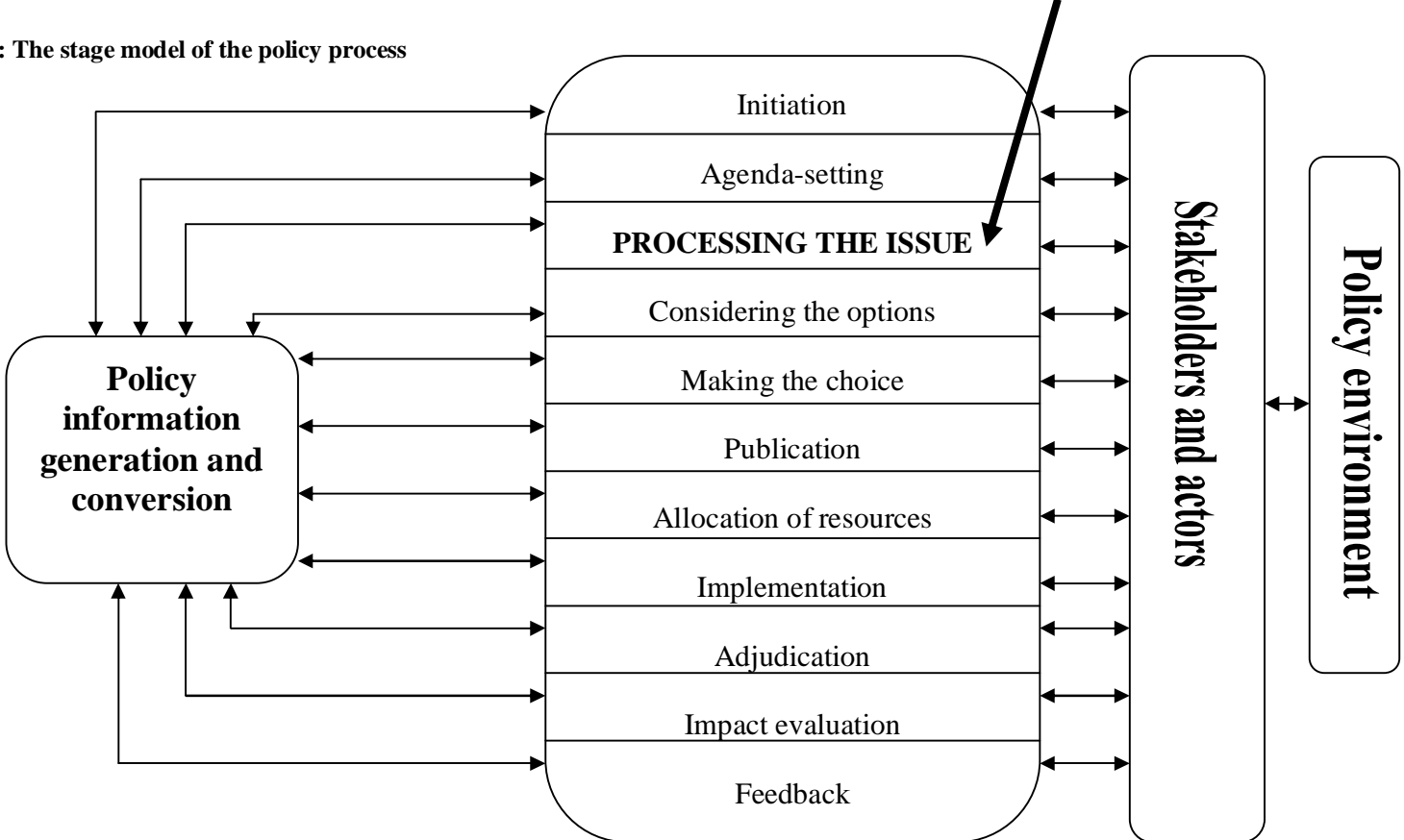
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Appendix: The stage model of the policy process



Source: Fox and Bayat (2006:53)

