

~~XXXXXXXXXX~~ INPUT FOR THE MINISTER OF HEALTH,
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Colloquium: Health within a Comprehensive System of Social Security: Is National Health Insurance an Appropriate Response?

Programme Director,
Distinguished guests
Ladies and Gentlemen

It gives me great pleasure to open this Colloquium organized by the Human Science Research Council. The question that is been addressed today is whether the National Health Insurance could be an appropriate vehicle to achieve social solidarity within the health care system or not.

This is not the first and the last time that a National Health Insurance system is advanced for funding health care in this country. As you all might know, the NHI policy was adopted by the ANC prior to 1994, and was contained in the ANC Health plan, ^{in May 1994.} ~~which~~ guides the transformation of the health sector. The quest for universal coverage and improved efficiency of our health system was also discussed during the ANC Policy Conference this year. The ANC policy conference reaffirmed its commitment to a National Health Insurance.

In fact, in 1994 the ANC recommended the establishment of "a Commission of Inquiry to look at the current crisis in the medical aid sector, and to consider alternatives such as a compulsory National Health Insurance (NHI) system."

That commission was mandated to investigate the appropriateness and economic feasibility of a National Health Insurance system within the South African context and undertake detailed planning for implementation of an NHI if there is sufficient consensus on this option.

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

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

- The current medical schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system.
- Membership would be compulsory for all formal sector employees and their dependants
- Schemes which form part of the NHI should be prohibited from excluding any member (eg on the basis of high-risk)
- The basic package of care to be covered by the NHI should be statutorily defined
- Contributions to cover the basic package would be income related, probably determined centrally, and should be jointly paid by employers and employees
- This contribution revenue (covering the basic package) should be pooled in a central equalisation fund, out of which every scheme would be paid in terms of its overall profile i.e. a risk adjusted capitation fee
- Existing health insurance companies and medical schemes would be free to offer 'top up' cover for services not covered in the NHI essential package

The long-term goal would be for all citizens including the unemployed to be covered under the NHI system.”

The question to ask is what progress have we made and what more should be done to achieve universal coverage in the national health system?

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

Medical schemes were re-engineered to support broad health policy objectives that of making private health care affordable.

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

We strongly felt that it would have been premature to introduce a Social/National Health Insurance system under conditions of serious fragmentation and financial instability in the medical schemes market in particular and the national health system in general.

The 'Medical Schemes Act of 1998' sought to promote access to affordable private health care for those who are able to pay for their health care. The "Act" came into effect in 2000. At the same time, Cabinet also appointed a Committee of Inquiry into Various Aspects of the System of Social Security in South Africa.

The Committee released its report in 2002. For Health, the Committee proposed that South Africa "moves toward a National Health Insurance system over time that integrates the public sector, and medical schemes environment within the context of a universal contributory system."

Subsequently, Cabinet adopted a Comprehensive Social Security Framework based on a Pillar approach. The Pillar 1 of this framework is intended to provide a universally available basic benefit for all citizens and specified classes of legal resident.

The Pillar 2 entrenches the contributory environment over-and-above Pillar 1, characterized by strong mechanisms to ensure social solidarity through, income-based cross-subsidies, risk-related cross subsidies and mandatory participation.

The Pillar 3 makes provision for the discretionary social security over-and-above minimum levels regarded as essential.

The challenge for us is to think carefully on how to achieve social solidarity for the health sector within this Comprehensive Social Security Framework?

You are all aware that solidarity is the crucial ethical and economic foundation for risk pooling and redistribution. The solidarity principle is that: people contribute according to their *means* and benefit according to their *needs*.

The two main means of achieving social solidarity in health care financing are the general tax system and compulsory health insurance. Some countries (like the UK or Sweden) have chosen the tax route, while others (like France, Germany or countries of Latin America) have chosen the insurance route.

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

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

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

This now brings me to the issue of Social Health Insurance and National Health Insurance. I noticed that the terms national health insurance (NHI) and social health insurance (SHI) are sometimes used loosely and (confusingly) interchangeably.

My understanding is that *National health insurance* provides benefits for both contributors and non-contributors in a universal system whereas *Social health insurance* benefits contributors only.

move quickly toward a national health insurance in the short to medium term. We are analysing whether there are any building blocks that can be put in place to make us move smoothly towards the NHI, either shortly, or in the long run.

We therefore remain committed to a National Health Insurance system as the end goal. How we get there, is still a subject for debate, which includes consideration of whether we can introduce a social health insurance as a means of achieving that end goal.

Such a Social Health Insurance system would cover three elements in this country. These elements are:

1. Government-mandated health insurance cover for specified groups.
2. Income cross-subsidies among contributors
3. Risk-related cross-subsidies among contributors

GOVERNMENT MANDATED HEALTH INSURANCE

We have learnt that most developed and some developing countries use compulsory health insurance contributions to finance their health services. The advantages of compulsory health insurance are widely documented and do not need further elaboration.

However, what we are grappling with is whether to go with individual mandates or employer mandates. For example, employer mandates form the backbone of health systems in Europe, Latin America and Asia. The key question to ask is whether this should also form a backbone of health systems in Africa, particularly South Africa.

The government has taken an initiative through the Government Employees Medical Scheme to introduce these mandates. On the contrary, the Old Mutual Health Survey has shown that companies are abdicating their responsibility with regard to the financing and provision of health care, which may make these mandates unachievable.

Nonetheless, in the short to medium term, we believe that medical scheme's contribution should be mandatory for those who can afford to make some contribution towards their health care. Obviously, the mandates will have to be effected in a

systematic and a phased approach, starting with either high-income earners or specific group of employers.

INCOME SOLIDARITY AMONGST CONTRIBUTORS

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

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

HEALTH RELATED CROSS-SUBSIDIES AMONG CONTRIBUTORS

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

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

The establishment of REF, which will be fully operational in 2009, will aid to stabilise risk pooling in medical schemes and provide a vehicle for the implementation of Social Health Insurance.

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

There are also issues related to the best vehicles for advancing the National Health Insurance Systems. Countries like Germany, the Netherlands, Switzerland and Belgium have used medical schemes to advance their Social Health Insurance Systems. Our experience here may be different precisely because:

- Almost every year, the Medical Schemes increase the contributions paid by the members
- There is an increase in non-healthcare costs viz; administration, managed care and broker fees.
- There is also an increase in Hospital and Specialists costs
- There is no direct relationship between the quality of healthcare rendered and these increases.
- There is a decrease in the medicine costs BUT no decrease in the total cost of healthcare.

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

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

express our views here, which may prejudice whatever decisions we need to take in future.

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