



Case Study

SOUTH AFRICAN SOCIAL HEALTH INSURANCE DEVELOPMENT IN THE 1990s: HOW DESIGN INFLUENCED ACTORS' POSITIONS

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¹ Gilson L., Doherty J., McIntyre D., Thomas S., Brijlal V., Bowa C. and Mbatsha S. (1999) The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-99. Monograph No. 66, Johannesburg: Centre for Health Policy, University of Witwatersrand/ Cape Town: Health Economics Unit, University of Cape Town.

1. OBJECTIVES OF CASE STUDY:

To use the South African experience of SHI development in the 1990s to:

- understand the influence of actors over SHI design and implementation;
- explore the types of SHI objectives and design details likely to impact on different actors;
- consider the formal and informal mechanisms that give actors influence in policy development;
- provide a foundation for determining the types of strategic actions that can be used to support SHI development.

2. STRATEGY FOR UNDERTAKING CASE STUDY WORK:

- Step 1: Introduction to South Africa and its process of SHI proposal development between the early 1990s and 1999
- Step 2: Discussion in small groups focussed on the tasks listed in section 4. These tasks focus attention on the responses of key actors to the details of past South African SHI proposals.
- Step 3: Report back in plenary. Each small group will report back primarily on their discussions of Task B, but will also contribute to plenary discussion of Tasks C and D. (See section 4).
- Step 4: Wrap up of case study discussions.

3. KEY FEATURES OF THE SOUTH AFRICAN CONTEXT:

Demographic and socio-economic context²

Population

- total population of 40.6 million (1996)
- 54% lived in urban areas (1996)
- 13.7 million economically active people (1996)
- 34% of economically active unemployed (1996)
- 36% of economically were employed in the formal business sector (1998)

Income inequality:

- middle income country: per capita income of US\$3160 (1995)
- Gini coefficient of nearly 0.6 (mid 1990s)
- the poorest 40% of households account for only 11% of total income but the richest 10% of households capture 40% of total income (mid-1990s)

² Statistics South Africa (2000). Statistics in brief 2000. Pretoria: Statistics South Africa; May J (ed) (1998) Poverty and Inequality in South Africa. Report prepared for Office of the Executive Deputy President and Inter-Ministerial Committee for Poverty and Inequality. Durban: Praxis Publishing

The South African health system: the apartheid legacy^{3,4}

- The health system is costly, fragmented, inefficient and inequitable
- SA spends a relatively large amount on health care (about 8% of GDP) but has relatively poor average health status indicators e.g. infant mortality rate estimated as 54/1000 live births in 1990/91 (revised to 45 per 1000 by the 1998 Demographic and Health Status Survey) [*Zimbabwe, in contrast, had an infant mortality rate of 48/1000 in 1990/91 but had an income level around a quarter of that of South Africa (US\$650) and spent only around 3% of GDP on health care*]
- SA has large inequalities in health: for example a five to six fold difference in infant mortality rates between the African and white populations and a three-fold difference between the highest and lowest income households

The South African health system is divided between

- the public sector, serving the majority of the population, the lower income groups, and
- the private sector primarily serving the middle and high-income groups that represent the minority of the population

In 1992/93 the private sector:

- routinely served only 23% of all South Africans
- accounted for 58% of total health care expenditure
- captured the majority of all types of health personnel (except nurses)

The public sector = services provided directly by government and funded from conventional tax revenue

The private sector = several different sub-sectors funded through various combinations of insurance premia, employer contribution and out of pocket payments.

The four main sub-sectors within the private sector are:

(1) *Medical aid schemes* (the main form of private medical cover):

- employer-based, voluntary schemes offering comprehensive benefits to members and their dependents
- schemes are not themselves allowed to make profits but are managed by administrators who are profit-making
- members and their employers make monthly contributions to the schemes; a tax deduction is available on the employer contribution
- the schemes reimburse providers, primarily on a fee-for service basis (with some co-payment). The use of this payment mechanism is one of the important reasons for the high levels of cost escalation experienced within the South African private health sector.

³ McIntyre D, Bloom G, Doherty J, Brijlal P (1995). Health expenditure and finance in South Africa. Durban: Health Systems Trust and World Bank.

⁴ van den Heever A (1997) Regulating the funding of private health care: the south African experience. Chapter 10 in Bennett S., McPake B and Mills A (eds) Private health providers in developing countries: Serving the public interest? London: Zed Press

- as employees of all backgrounds are members of the same medical scheme the schemes usually involve a cross-subsidy from health to unhealthy and relatively high to relatively low income (but not to the lowest income groups served by the public sector).
- in 1994 there were 169 such schemes.

(2) *Health insurance* (a form of private insurance that grew substantially over the 1990s):

- offered by insurance companies as one of a variety of insurance products, on a for-profit basis
- benefits are explicitly defined, comprehensive cover is not supported
- benefits are funded through a mix of a premium and co-payments
- there is no cross-subsidy between healthy/unhealthy and high/low income groups through these products
- the products have specifically sought to attract the higher income/more healthy people away from medical schemes by offering them a lower cost product (because there is no cross-subsidy to other groups)

(3) *Employer-provided care*:

- services directly provided and financed by employers (such as the large mining companies), primarily for lower income workers.

(4) *Out-of-pocket payments*:

- the purchase by all income groups of private primary care, particularly the services of general practitioners, through direct payments.

Although the institutionalised racism of the apartheid era reserved the private sector for the white population, the powerful trade union movement began to demand access to it for its lower income, African and Indian members over the 1980s. This led to the provision of some employer-based medical benefits for people who had previously relied exclusively on the public sector. But as these were still largely funded separately from the traditional medical aid schemes, virtually no income-related cross-subsidy occurred within the newer schemes. Nonetheless, this development did increase demand for privately-funded medical benefits from lower income groups – particularly in the face of a perceived decline in the quality of public services.

The evolution of social health insurance proposals

Anticipating a new government, towards the end of the 1980s the health policy community inside South Africa began debating policy matters. A key element in these debates was the form that the health system should take after the election of a democratic government, and the role of the private sector within that system. Some favoured a tax-funded national health system along the UK lines. Others suggested that some form of insurance-based system would be more technically and politically feasible as an immediate goal. The second group's views won the day. They began to develop initial ideas around the design of an insurance-based system and the African National Congress's Health Plan, published in 1994, recommended that a commission be established to investigate the appropriateness and feasibility of an insurance-based option, through consultation with interested parties.

This proposal was then fed into a series of ad hoc committees established after 1994 to advise government on these issues. The three main committees that considered SHI between 1994 and 1999 were:

The Health Care Finance Committee (HCFC) of 1994:

- established by the new national Minister of Health as a body to advise her on a range of financing issues
- comprised 17 members drawn from the South African academic community, government structures and private sector (1 member from the medical aid scheme environment), with three international advisors
- worked over a 6 month period, behind closed doors
- proposed three insurance options in a confidential report to the Minister: one of these came to be known as 'the Deeble option', after the international adviser who proposed it, and following a leak to the press became the subject of much media debate

The Committee of Inquiry into a National Health Insurance System of 1995:

- established by the national Minister of Health to provide advice on how to fund the provision of primary care access to all South Africans (either through an insurance-based system or through a tax-funded alternative)
- a key starting point of its deliberations was the government's intention to remove all public primary care fees (finally announced in 1996)
- in practice its deliberations included a broader investigation of insurance options and of how to regulate the private insurance industry
- comprised 13 members, drawn from the South African academic and government community, with 2 private sector analysts, 2 Department of Finance representatives and 3 international advisers
- worked over only a four month period, and involved both detailed face to face discussions with key stakeholders such as the medical aid schemes as well as public consultations around the country
- published a draft report for public comment in mid-1995 and a final report in 1996

The SHI Working Group of 1997:

- established by the Department of Health's Deputy Director General (equivalent to deputy principal/permanent secretary)
- comprised only 6 members drawn from the academic community and national Department of Health
- specifically tasked with developing detailed proposals for an SHI scheme for low income groups that would support public hospital use
- met periodically throughout 1997
- proposals were submitted to and approved by the structure ten national and provincial ministers of health

However, despite the work of these three committees, SHI had not moved into an implementation phase by 1999, the end of the first government's term of office. Instead, following a decision of the 1997 national meeting of the African National Congress,

social health insurance is currently (2000) being re-considered within the context of a broader review of social security.

Yet, in contrast, the South African parliament passed the Medical Schemes Act in 1998 - legislation that is supporting the re-regulation of the private insurance sector. Although initially intended to be developed with SHI, the regulation proposals were eventually developed through a separate process.

The design of different SHI proposals, and the key actors involved in SHI debates
Tables 1 and 2 provide some further information from the South African experience. Table 1 gives details of the design of different sets of SHI proposals; and Table 2 identifies the range of relevant actors in these debates, their interests and the levels and sources of power they brought to the debates.

4. TASK (use Tables 1 and 2):

- (A) Spend an initial 10 minutes quickly reviewing Tables 1 and 2 (especially Table 2!).
- (B) Your group has been allocated 1 or 2 key actors by the facilitator. Given the information you have received, how do you think each of these actors responded to the SHI proposals of 1995 and 1997? (See Table 1: note that the details of the 1994 'Deeble option' are only included as background information)
- (C) Of the full range of actors identified in Table 2, which two do you think are likely to have had most influence over SHI proposal development - and why?

South African Social Health Insurance Development in the 1990s

TABLE 1: SOUTH AFRICAN SHI PROPOSALS, 1990s			
	1994 (the 'Deeble option')	1995	1997
Main objectives of proposals	1. Control private sector 2. Expand coverage and promote greater cross-subsidisation between people and public/private sectors	1. Generate revenue for the public sector 2. Expand coverage and some increased cross-subsidisation between people and between public/private sectors 3. Improve efficiency of service provision	1. Generate revenue for the public sector 2. Expand coverage and some increased cross-subsidisation between people served by the public sector 3. Improve efficiency of service provision
Beneficiary group	Total population	Formally employed	Formal sector employees, particularly targeting the lower income and currently uninsured
Contributors	All employed	Only formally employed	Only those formally employed and currently uninsured
Basis of membership	Compulsory	Voluntary	Compulsory for target group and voluntary for informally employed
Benefit package	Primary care only	Defined public hospital package (with better hotel services for insured)	Defined public hospital package
Benefit provider	Network of existing public primary care facilities plus all private GPs contracted to state	Public or private hospitals (top-up cover of private primary or hospital care allowed)	Primarily public hospitals (top-up cover from private sector allowed)
Benefit funding mechanism(s)	Payroll tax of about 3% on all tax payers with equal payment by employer and employee	Income-related employer/employee contributions; PLUS risk equalisation mechanism between medical aid schemes	Shared employer/employee contributions
Provider payment mechanism	Private providers to contract with insurance scheme in rural areas; payment by some form of risk-related capitation, plus user fees	Unclear	Some form of re-imburement
Regulation	GPs required to offer comprehensive package of preventive and promotive services	To define core benefit package and to ensure adequate risk-sharing in insurance industry	To define core benefit package and ensure target group take out public hospital insurance
Administrative	New public sector body to be sole	Special state hospital body OR	Statutory SHI authority located

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body	purchaser	through existing medical aid schemes	outside civil service to manage scheme (plus small administrative role for medical aid schemes)

TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99		
ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
The public	<p>The uninsured:</p> <ul style="list-style-type: none"> To improve security of access and sense of social protection <p>The insured:</p> <ul style="list-style-type: none"> To maintain and improve existing benefits at reduced or lower cost. 	<p>The uninsured:</p> <ul style="list-style-type: none"> Some broad <u>political</u> power through the democratic process and through membership in trade unions but <u>no direct influence over SHI debates</u> which largely occurred 'behind the closed doors' of government and committees. <p>The insured:</p> <ul style="list-style-type: none"> Some broad <u>political</u> power through the democratic process but <u>no direct influence over SHI debates</u>.
Private providers	<ul style="list-style-type: none"> To secure or improve incomes and working conditions by obtaining access to a large pool of private patients To increase access to new technologies in order to improve quality of care 	<ul style="list-style-type: none"> Potential <u>economic power partially contained</u> by fragmentation and competition within sector <u>Limited political power</u> in the post 1994-era Organised <u>medical profession weak</u> because main organisation discredited by history and considerable fragmentation among alternative organisations <u>Roles within SHI discussions limited</u> to making submissions to some committees Technical <u>knowledge of own operations</u>.
Employers	<ul style="list-style-type: none"> To limit costs by keeping premiums low To secure benefits for workers To improve labour relations 	<ul style="list-style-type: none"> <u>Economic power</u>, harnessed through various organisational structures <u>Limited political power</u> <u>No formal role in SHI discussions</u> but regular meetings with government and trade unions on broader macroeconomic and labour issues Technical <u>knowledge of its own operations</u>
Trade Unions	<ul style="list-style-type: none"> To expand and improve health care coverage for poorer groups within society To consolidate or expand the current benefits available to their own members 	<ul style="list-style-type: none"> Strong <u>political power</u> through formal alliance with the African National Congress and role in anti-apartheid struggle Potential <u>economic influence constrained</u> by political alliance and allegiances (limiting strike action, for example) <u>No formal role in SHI discussions</u> <u>Limited technical capacity</u> to support direct engagement in these discussions.

South African Social Health Insurance Development in the 1990s

TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99		
ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
Medical schemes	<ul style="list-style-type: none"> • To maintain market share and revenue levels, and if possible expand it • To counter proposals hostile to its interests • To support the new government in expanding access 	<ul style="list-style-type: none"> • Considerable economic power initially harnessed through a single structure (the Representative Association of Medical Schemes: RAMS) but later undermined by fragmentation within industry • Limited political power after 1994 but considerable tactical awareness, and some strategic action • Given formal place in SHI committees of 1994 and 1995 • Technical knowledge of its own operations
Government : Department of Finance	<p>All objectives rooted in the relatively conservative post-1996 macro-economic framework which aimed to promote economic growth by encouraging private international and national investment</p> <ul style="list-style-type: none"> • To improve efficiency in government expenditure • To contain public expenditure levels and reduce the government deficit • To contain the tax: GDP ratio • To protect the 'already highly taxed' middle income from further taxation • To ensure accountability for government expenditure 	<ul style="list-style-type: none"> • <u>Strong political and economic power</u> as the central economic ministry within the newly-elected government, charged with ensuring implementation of the politically high profile and well-accepted macro-economic policy (particularly after 1996) • <u>Strong role in all policy processes</u> concerning government policy on financing and expenditure issues, although varying formal role within SHI discussions • <u>Strong technical capacity</u> only enhanced other forms of power

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TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99		
ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
Government : Department of Health	Objectives not clear but broadly a combination of: <ul style="list-style-type: none"> Improving equity through strengthening cross-subsidisation mechanisms (between sectors of the system and between population groups) Revenue generation for public sector <p>Apparently changing over time from stronger emphasis on cross-subsidisation towards stronger emphasis on revenue generation</p>	<ul style="list-style-type: none"> <u>Some political power</u> from leading role given to the health sector in formal ANC policy documents, and from personal standing of Minister in government; <u>but contained</u> by position as spending ministry subject to overall government economic policy <u>Technical and managerial capacity undermined</u> by broader evolution of governmental structures, appointment of new government personnel, limited technical knowledge and understanding of new personnel of health financing issues
Minister of Health	<ul style="list-style-type: none"> To improve access to health care particularly for the poor and rural populations, preferably through government controlled funding arrangements <p>(and cautious about profit-motivated private health sector)</p>	<ul style="list-style-type: none"> <u>Strong political power</u> from being in health sector base, itself seen by the ANC as a sector where speedy change to redress the apartheid legacy could be implemented, and from personal standing within ANC (personal backing of President and Deputy President) <u>Strong formal role</u> in health and wider policy processes, as national Minister of Health and cabinet member Additional influence from <u>clear values and stated goals</u>, and from decisive management style
Health economists advising government	<ul style="list-style-type: none"> To develop a technically and politically feasible insurance-based funding mechanism with which to support overall health system development <p>(over time, possibly accepting less emphasis on cross-subsidy and more on revenue generation for the public sector)</p>	<ul style="list-style-type: none"> <u>No economic or political power</u> Strong <u>formal role in SHI committee processes constrained</u> by the way in which the committees functioned (e.g. limited time, too many issues, little interaction with senior policy-makers) <u>Technical capacity constrained</u> by limited understanding of their role among DOH officials and by their own weak strategy