Paying for Intervention!

How statutory intervention harms South African health care

Jasson Urbach

Health Policy UNIT

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About the Health Policy Unit

The Health Policy Unit (HPU) is dedicated to promoting a sound economic and business-friendly policy approach to the provision and funding of health care. HPU promotes the private supply of competitive healthcare services and the incremental extension of private funding of health care as the most effective method of supplying high quality health care to the South African population.

HPU urges government to devote its limited health budget to the supply of services to the poor, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, enabling it to provide services to an increasing percentage of the population.

HPU is a division of the Free Market Foundation (Southern Africa), an independent non-profit policy organisation (No 020-056-NPO) which promotes and fosters an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles.

About the author

Jasson Urbach obtained a Bachelor of Commerce degree, majoring in Finance and Economics, at the University of Natal in Durban, South Africa. He then completed an Honours and a Masters degree in Economics. The subject of his Masters' dissertation was *The Determinants of Labour Force Participation of the Elderly*. He works as an economist for Africa Fighting Malaria as well as the Free Market Foundation and is a Director of the Health Policy Unit. He is the author of several academic papers and opinion pieces, many of which have been republished in the popular media.

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Johannesburg: PO Box 785121, Sandton 2146, South Africa • Tel: 011 884 0270 • Fax: 011 884 5672 • Email: fmf@mweb.co.za

Cape Town: PO Box 805, Cape Town 8000, South Africa • Tel: 021 422 4982 • Fax: 021 422 4983 • Email: fmf.ct@mweb.co.za

Websites: www.freemarketfoundation.com • www.healthpolicyunit.org

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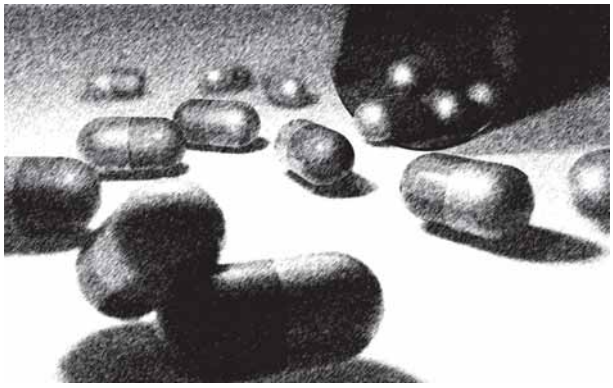


Executive Summary

In 1998, the medical scheme market in South Africa was dramatically altered when the SA government introduced a new Medical Schemes Act. The changes in policy were intended to move SA towards a Social Health Insurance (SHI) system, and, ultimately, a National Health Insurance (NHI) system. The purpose of this paper is to examine the effects of this legislation and offer insight into the likely outcome and appropriateness of a socialised healthcare system for SA.

It is argued that these policies involve a conflicting mix of social and efficiency objectives that entail a number of unintended consequences which have dramatic and far reaching implications for the SA healthcare market. A NHI style system is simply not affordable for a poor developing country such as SA and will result in sub-standard levels of care for SA's citizens. Furthermore, it is argued that a nationalised system is based on false promises and is not sustainable given the increasing burden on the small tax base, the antiquated infrastructure within the public health sector and SA's aging population.

A socialised healthcare system in SA will also have the unintended consequence of exacerbating the massive exodus of skilled personnel, the so-called 'brain drain'. However, far from attempting to increase the supply of skilled personnel, the SA government continues to restrict the number of skilled healthcare professionals entering SA as well as the number of positions available at tertiary education facilities. It is recommended that, in order to increase the number of skilled medical personnel, the government relax the restrictions on foreign skilled medical personnel entering and practising in SA and allow the private sector to train prospective students.

Finally, it is argued that the private health insurance market has a significant role to play in alleviating the burden on the public sector by increasing the number of individuals enrolled in private medical schemes. To enable them to do this, the government should amend the legislation compelling medical schemes to provide a minimum package of benefits known as prescribed minimum benefits. These benefits have the unintended consequence of raising the cost of medical scheme options, which prevents certain groups of individuals from accessing private medical schemes. Furthermore, given SA's aging population and the fact that healthcare expenditure increases as age increases, it is argued that the current system of cross-subsidisation is unsustainable. Medical schemes should be allowed to rate individuals according to their risks so that individuals pay premiums commensurate with their expected health outcomes – the only feasible option to avoid any future disappointment.❐

Introduction

Healthcare policy in South Africa is a highly emotive and contentious issue fuelled by the stark dichotomy between the public and private healthcare sectors. Generally speaking, on the one hand, the public health sector is plagued with inefficiency and for the most part fails to meet the needs of the patients it is supposed to be serving. The result is that patients seldom receive the level of care that they deserve. On the other hand, the private healthcare sector provides a world-class health service with excellent facilities, advanced technology, well-remunerated staff and by and large better working conditions.

Public sector healthcare delivery is financed primarily out of general taxation whereas private patients typically cover their costs through medical schemes to which they or their employers make contributions. Private medical schemes thus provide the main channel for accessing private health care in SA. However it should be noted that a significant amount of out-of-pocket healthcare purchases are also undertaken in SA in order to access private health care.[1] Medical schemes operate on a non-profit basis but their administration is typically contracted out to for-profit companies whose main tasks are to collect premiums, process claims and contract with providers on behalf of medical scheme members.[2]

Private insurance can also take the form of health insurance. Health insurance, like any other form of insurance, can be obtained from insurance companies and generally covers the individual for a set amount per day for hospital needs. Alternatively, the insurance provider may pay a set fee for specific procedures. Whereas medical schemes typically reimburse the service provider directly for procedures or services rendered by healthcare providers, health insurance requires the patient to settle the bills and complete the paperwork. Any surplus that the insurance company pays out, over and above the cost of the procedure, the individual is allowed to keep. Similarly, the individual is responsible for any deficits owing to the service provider for procedures that are not covered by the lump sum pay out.

Given the significant proportion of financial and human resources within the private sector, the continuation and expansion of this sector is of vital importance to SA's overall health and welfare (see Annexure 1). Considering the concentration of resources in the private healthcare sector and the fact that private medical schemes provide the main vehicle for accessing private health care, it is surprising that the SA government has introduced draconian legislation that plans to limit the scope and extent of the private sector, particularly when one considers the poor record of the SA public health sector.

The number of individuals covered by private medical schemes has remained relatively static since 1997. The current medical scheme legislation is partly responsible for this relative stagnation in medical scheme beneficiaries. Moreover, the government's intention to introduce a form of mandatory health insurance, with a target of covering 15 million people, incurs a number of unintended consequences.[3] The move to increase the number of people covered by medical schemes should be welcomed by all South Africans but how best to achieve this objective should be carefully considered.

Section 1 introduces the theory of economic freedom, the basis of the arguments presented in this paper, which, generally speaking, advocate that greater levels of economic freedom lead to greater levels of economic prosperity and better health outcomes.

Section 2 provides an analysis of demographic trends in SA. More specifically, it utilises a forecasting model developed by the United States Census Bureau to calculate a demographic profile for SA at various points of time in the future, which predicts that SA's demographic profile will shift towards an older population as the mean age rises over time.

Section 3 presents data depicting the numbers of individuals enrolled in private medical schemes.

Section 4 examines the effects of the Medical Schemes Act of 1998. It is argued that a number of unintended consequences have arisen as a result of the legislation and the future of SA health care should revolve around policies that place greater emphasis on the role of individuals in the healthcare market.

Section 5 describes the importance of tax deductions on medical schemes

Section 6 offers solutions to the so-called 'brain drain' and by extension the chronic shortage of skilled healthcare personnel currently plaguing the SA healthcare market. Among the common reasons cited for the mass exodus of skilled healthcare personnel from the public sector are poor salaries, high workloads, poor work environments and few opportunities for advancement. These push factors result in many healthcare workers choosing either to exit the public sector in the hopes of finding employment within the private sector or leaving SA to seek for job opportunities abroad. The resulting shortage of skilled healthcare personnel in SA reduces the quality of care for all South Africans and it is thus vital to increase the supply of these professionals in order to address that shortage.

Section 7 deals with the question: Is a National Health Insurance system appropriate for SA? It is contended that SA is simply not in a position to provide free health care for all. SA's expenditure on health care has increased at a phenomenal rate since 1994. Yet despite this cash injection conditions within the public sector remain unfavorable, resulting in a poor level of service to users of the facilities. Nearly 50 per cent of provincial budgets already go towards healthcare spending and healthcare costs are expected to continue to rise. SA's antiquated public sector infrastructure and aging population make it seriously doubtful whether the government is justified in wanting to introduce a NHI style system. New investment in the health sector is an essential priority but considering the government's poor track record in maintaining public health sector facilities it is not unreasonable to assume that the necessary investment will not be forthcoming in the near future. The private sector should therefore continue to play a significant role in the future of the healthcare market. Given that medical schemes represent the main channel for accessing private health care it is clear that legislation which negatively impacts this sector will have the same effect on the private provision of care.

Section 8 provides a conclusion to this paper.❐

1. Economic Freedom & Better Health Outcomes

Only with economic growth and increased incomes will South Africans gain greater access to medicines and hospital services. Government should focus on adopting policies that foster economic growth by increasing the level of economic freedom in the country. The evidence that greater levels of economic freedom and increased wealth lead to better health outcomes is clear and unambiguous.

SA's ruling party, the African National Congress (ANC), fought hard for many decades so that ordinary people could have the right to vote, to make their own choices and to determine their own future. What could be more liberating than to allow people to make their own choices about their health and how to spend their money?

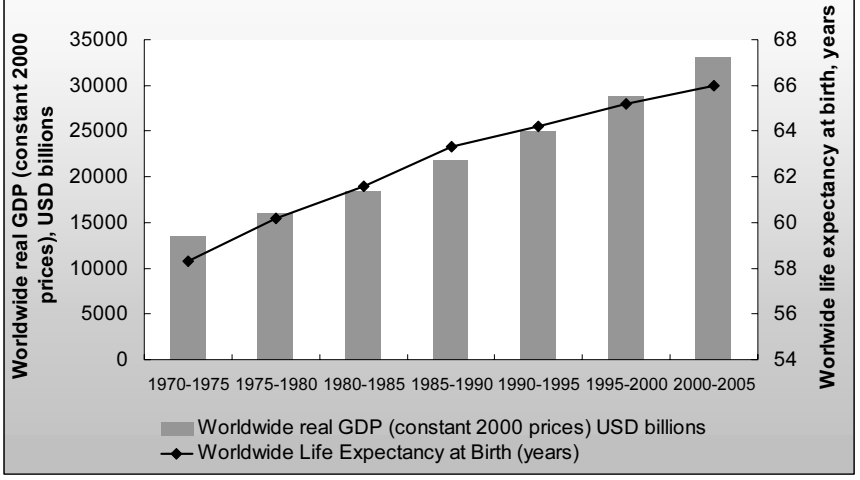
If the SA government adopted policies that allowed individuals to increase their wealth, people would be able to afford private health insurance. "Economic theory dating back to the publication of Adam Smith's The Wealth of Nations in 1776 emphasises the lesson that basic institutions that protect the liberty of individuals to pursue their own economic interests result in greater prosperity for the larger society".[4]

The evidence that greater levels of economic freedom and increased wealth lead to better health outcomes is clear and unambiguous.

1.1 Wealth and health

Worldwide gross domestic product (GDP) has increased significantly since 1970 from US12,332 billion to US36,205 billion in 2005 (in constant 2000 prices). At the same time life expectancy worldwide has increased from an average of 58.3 years in 1970 to an average of 66 years in 2005 (see Figure 1). The correlation between wealth and health is by no means serendipitous – as nations get wealthier, more money becomes available for expenditure on health care.

Figure 1: Worldwide: Gross Domestic Product (GDP) and life expectancy, 1970-2005



Sources: World Bank – World Development Indicators;[5] *Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat;*[6] *author's own calculations*

The landmark article by economists Lant Pritchett and Lawrence Summers shows the dramatic effect that increases in incomes can have on health. Pritchett and Summers found a strong causative effect of income on infant mortality and demonstrate that if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted.[7]

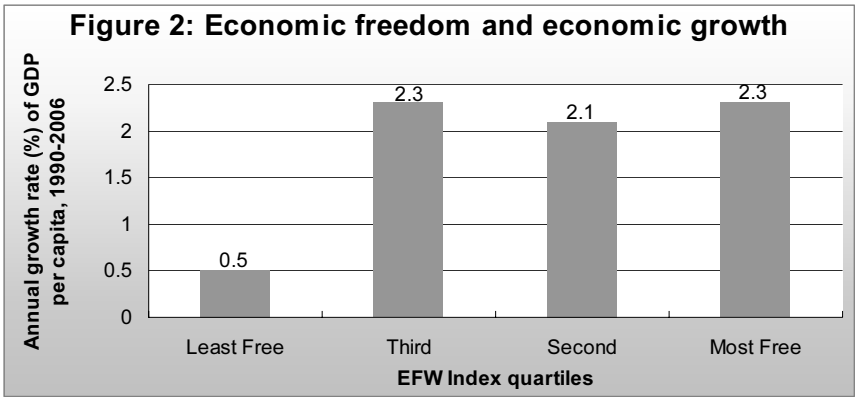
During the second half of the twentieth century, the diffusion of technology from rich to lower-income countries, as well as greater wealth in lower-income countries, led to what has been described as the third of three great waves of mortality decline.[8] Increased access to safe water and sanitation in lower-income countries, as well as greater access to basic public health services, greater knowledge of basic hygiene, and new technological developments (such as antibiotics and tests for early diagnosis) were instrumental in reducing mortality rates across the globe. Revolutions in agriculture also resulted in increased food supplies throughout the world. The combination of these factors, facilitated by trade between rich and poor nations, led to longer life expectancies worldwide – not just in the richest nations.[9]

1.2 Economic freedom and health

One of the surest ways to increase wealth in a country is to embark on trade and economic reforms that result in higher levels of economic freedom. One of the key objectives in the Economic Freedom of the World (EFW) annual report is to establish whether relationships exist between economic freedom and economic growth. The 2008 EFW report measures the degree to which the policies and institutions of the 141 countries surveyed support economic freedom. The foundations of economic freedom are personal choice, voluntary exchange, freedom to compete and security of privately owned property. Forty-two data points are used to construct a summary index and to measure the degree of economic freedom in five broad areas: (1) size of government; (2) legal structure and security of property rights; (3) access to sound money; (4) freedom to trade internationally; and (5) regulation of credit, labour and business.

The findings in the report unambiguously support the fact that economic freedom is strongly related to prosperity and growth – countries that are economically free tend to grow faster and be more prosperous.[10] According to the 2007 EFW report, "Without voluntary exchange and entrepreneurial activity coordinated through markets, modern living standards would be impossible".[11] Evidence from the 2008 EFW report demonstrates that countries in the top quartile of the index experience average per capita economic growth rates of 2.31 per cent on average, whereas economies in the bottom quartile experience growth rates of 0.5 per cent on average.[12] In simple terms, countries with more economic freedom have higher growth rates.

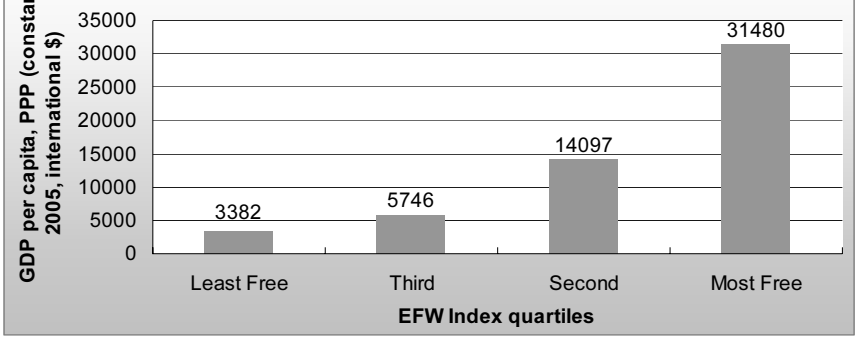
Figure 2: Economic freedom and economic growth



Sources: Fraser Institute; World Bank – World Development Indicators 2008

More specifically, research in the 2008 EFW report demonstrates that countries with more economic freedom have substantially higher per capita incomes. The top 25 per cent of the freest economies in the world have average per capita incomes of $31,480, while the least free economies for which data were available have per capita incomes of $3,382 (see Figure 3).[13]

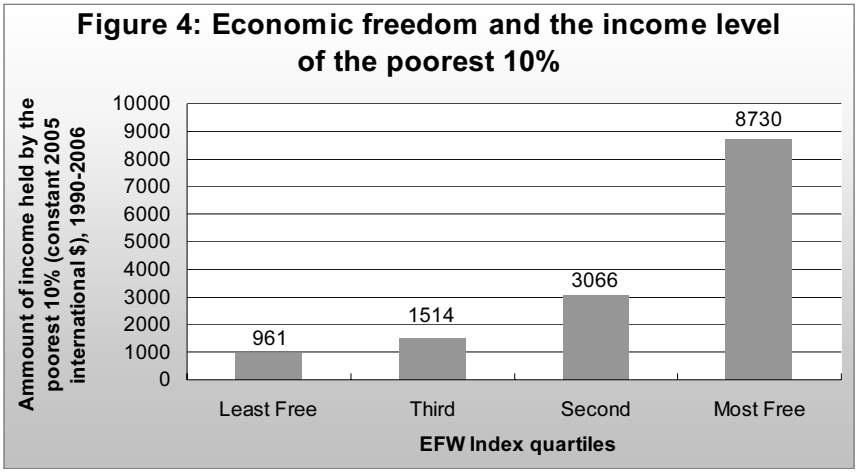
Figure 3: Economic freedom and income per capita



Sources: Fraser Institute; World Bank – World Development Indicators 2008

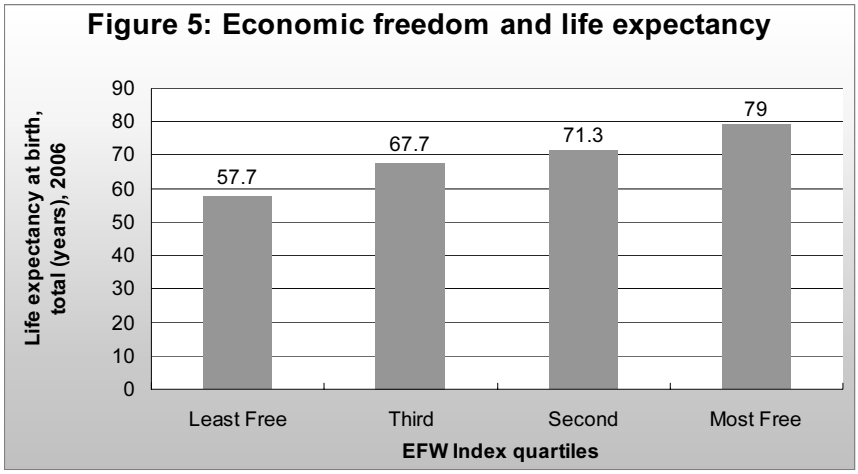
For nations scoring in the top quarter of the index, the average income of the poorest 10 per cent of the population was $8,730 compared to just $961 in the least free nations. This shows that economic freedom benefits everyone – both the rich and the poor get richer (see Figure 4).[14]

Figure 4: Economic freedom and the income level of the poorest 10%



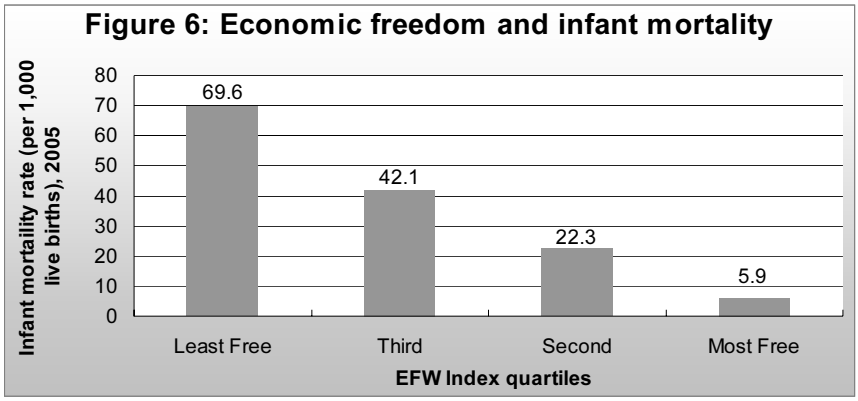
Sources: Fraser Institute; World Bank – World Development Indicators 2008

In simple terms, countries with more economic freedom have higher growth rates.



Sources: Fraser Institute; World Bank – World Development Indicators 2008

More importantly, life expectancy is over 20 years longer in countries with the most economic freedom than it is in those with the least amount of economic freedom. For countries in the top quartile of the index, life expectancy is 79.0 years but a mere 57.7 years for those falling into the bottom quartile of the index (see Figure 5).[15]



Sources: Fraser Institute; World Bank – World Development Indicators 2007

According to the EFW report, infant mortality is also much lower in countries with high levels of economic freedom. Countries in the bottom quartile of the index experience 69.6 deaths per 1,000 live births whereas the freest countries in the world experience merely 5.9 deaths per 1,000 live births (see Figure 6).[16]

1.3 Trade and health

In their paper 'Is Trade Good for your Health' (2004), Owen and Wu examine the relationship between a country's openness to international trade (one of the EFW components) and several health outcomes. In general, the paper finds, "Increased openness is associated with lower rates of infant mortality and higher life expectancies, especially in developing countries".[17] Owen and Wu present preliminary evidence suggesting that part of the explanation for the positive relationship between trade and health emanates from the knowledge spill-overs facilitated by increased trade. Intuitively this makes sense; technologies developed by more prosperous and technically advanced economies can only be transferred to developing economies that are open to trade.

Openness provides developing economies the opportunity to 'piggy-back' on technologies and 'leap-frog' up the developmental ladder.

Openness provides developing economies the opportunity to 'piggy-back' on technologies and 'leap-frog' up the developmental ladder. For example, developing countries may benefit from vaccines produced and manufactured in developed countries or from pharmaceutical drugs and devices, provided they allow them to enter the country without being delayed by bureaucratic procedures and other obstacles.

Moreover, Owen and Wu note with regard to health outcomes, the poorest countries have the most to gain from trading with those that are more technically advanced, whereas developed countries gain little or nothing from trading with other advanced nations. The authors state, "Increased trade is associated with improved health outcomes but these gains vary by country. In particular, these benefits are enjoyed primarily by poorer countries, while the benefits to more developed nations are much smaller, or even non-existent".[18]

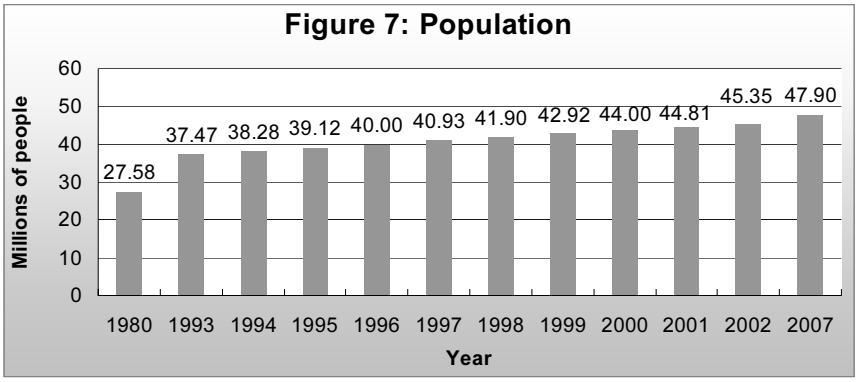
... freer countries tend to be wealthier and healthier and this is not true for just the richest members of society, but for all citizens.

In addition to the technological spill-overs that occur from having more open trade environments, Owen and Wu suggest that openness is associated with sound economic policies, which may increase health outcomes. The authors state, "One of the reasons that trade and health are positively correlated is simply because "good" government provides policies that are conducive to both trade and better health outcomes".[19]

The data presented above clearly demonstrates that countries which embark on trade and economic reforms that increase their levels of economic freedom, stand to gain substantially. The basic message is that freer countries tend to be wealthier and healthier and this is not true for just the richest members of society, but for all citizens.❐

2. South African Demographic Trends

The South African population traditionally has experienced relatively robust growth. Over the period 1975-1994, it grew at an average of 2.3 per cent per annum, reaching approximately 38 million people in 1994 (see Figure 11).[20] Since then, the rate of growth has slowed but remains positive. Over the period 1990-2006, the population grew at an average rate of 1.7 per cent[21] and for 2007, the estimated mid-year population was approximately 48 million people.[22]



Sources: World Bank Development Indicators, 2004; Data for the year 2007 come from Statistics South Africa: Mid-year population estimates 2007, statistical release P0302

According to the United States Census Bureau's International Data Base, the South African population is aging. In the year 2000, the median age was 23 years. This is projected to rise to approximately 28 years in 2015, and 33 years in 2050. This aging population trend is well demonstrated by the following table (see Table 1) and population pyramids that follow.[23]

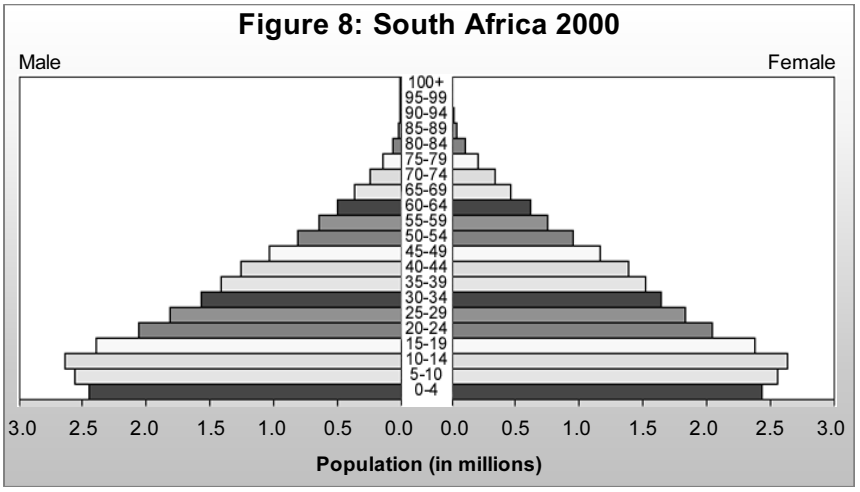
Table 1: Mid-year population estimates: 2000, 2025 & 2050

	2000	%	2025	%	2050	%
0-4	4,878,379	10.83	4,136,743	8.49	3,559,310	7.20
5-9	5,125,345	11.37	4,163,739	8.55	3,592,218	7.27
10-14	5,266,660	11.69	4,251,448	8.73	3,638,628	7.37
15-19	4,768,549	10.58	4,443,981	9.12	3,730,865	7.55
20-24	4,105,536	9.11	4,469,728	9.18	3,805,970	7.70
25-29	3,639,793	8.08	4,405,109	9.04	3,823,877	7.74
30-34	3,216,408	7.14	4,308,748	8.84	3,699,903	7.49
35-39	2,931,282	6.50	3,946,321	8.10	3,519,899	7.13
40-44	2,647,295	5.87	3,010,978	6.18	3,353,069	6.79
45-49	2,202,582	4.89	2,220,806	4.56	3,091,456	6.26
50-54	1,766,656	3.92	1,872,616	3.84	2,841,886	5.75
55-59	1,389,919	3.08	1,730,623	3.55	2,694,083	5.45
60-64	1,121,613	2.49	1,644,527	3.38	2,428,501	4.92
65-69	823,003	1.83	1,463,116	3.00	1,800,630	3.64
70-74	585,165	1.30	1,121,341	2.30	1,256,523	2.54
75-79	343,397	0.76	762,351	1.56	955,538	1.93
80+	253,516	0.56	762,303	1.56	1,608,272	3.26
Total	**45,065,098**	**100**	**48,714,478**	**100**	**49,400,628**	**100**

Source: United States Census Bureau, International Data Base

In the year 2000, the South African population pyramid (see Figure 8) exhibited a wide base, indicating the concentration of the population in the lower age cohorts, typical of developing nations. Indeed, more than one-third (33.8%) of the population was younger than 15 years of age. Less than 7 per cent of the population was of pension age (older than 60 years).[24]

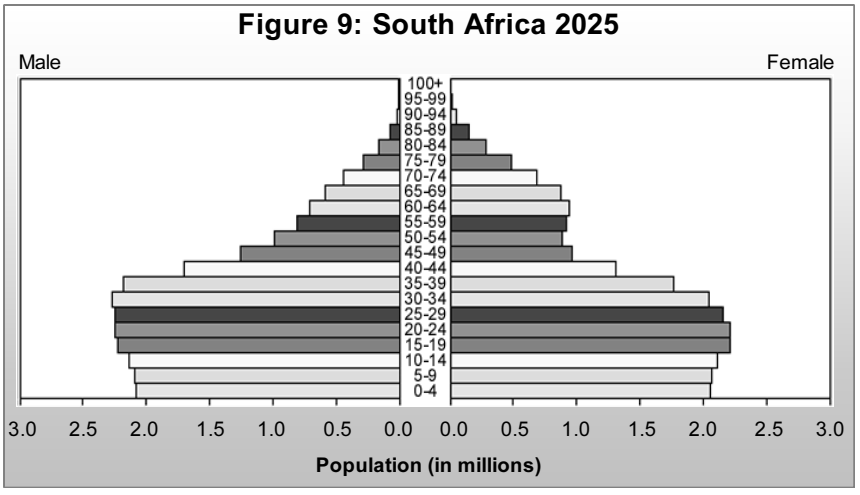
Figure 8: South Africa 2000



Source: US Census Bureau, International Data Base

By 2025, the percentage of the population younger than 15 years of age is projected to decline to approximately 26 per cent and the percentage of the population older than 60 years to increase to 12 per cent (see Figure 9). Approximately 24 per cent of the population will be 45 years and older.[25]

Figure 9: South Africa 2025

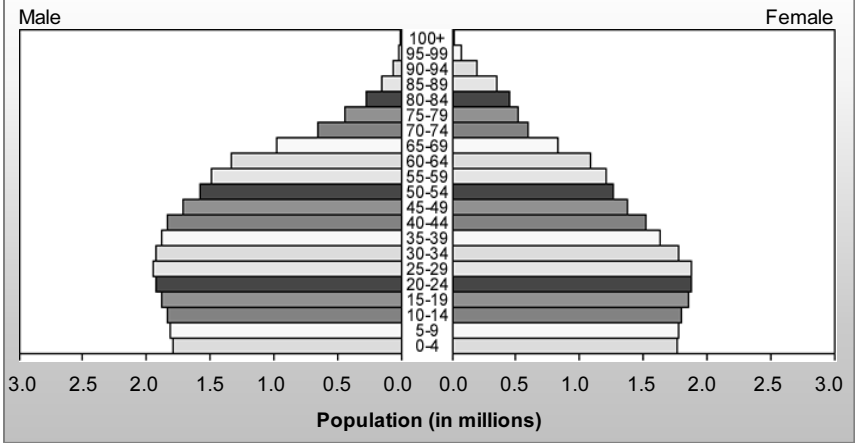


Source: US Census Bureau, International Data Base

With an aging population, healthcare financing requirements for the population in general will increase.

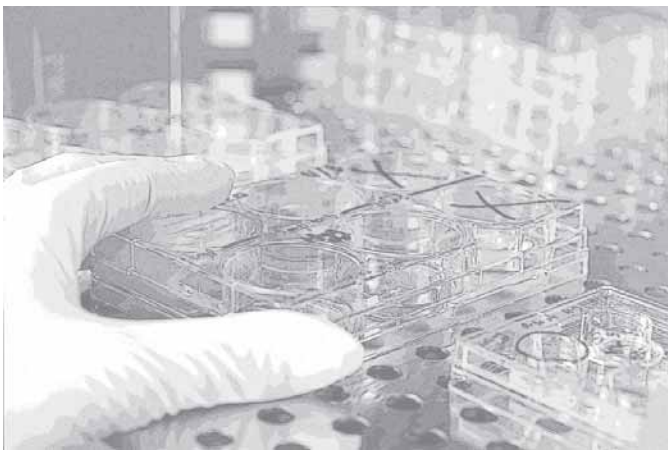
By the year 2050, the percentage of the population younger than 15 years of age will drop to less than 23 per cent, whilst the percentage of the population older than 60 years will increase to 16 per cent (see Figure 10). The percentage of the population older than 45 years will rise to over one-third of the total population.[26]

Figure 10: South Africa 2050



Source: US Census Bureau, International Data Base

This projected ageing population trend has dramatic and far-reaching implications for the way in which SA plans to implement its healthcare strategies. Older individuals tend to have greater medical requirements than younger ones. With an aging population, healthcare financing requirements for the population in general will increase. The implications of this trend are examined in more depth in Section 4.[27] ❐



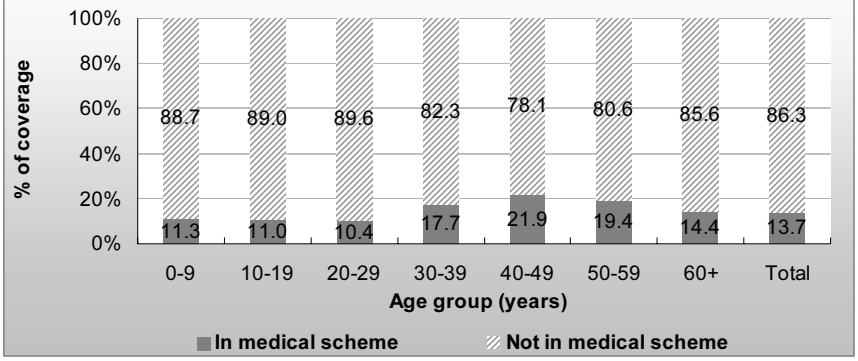
3. South African Medical Scheme Trends

The number of individuals enrolled in private medical schemes has remained relatively static for several years. Considering the significant amount of out-of-pocket purchases made by individuals seeking private medical care throughout SA, the slow growth in medical scheme membership may seem surprising at first. One would imagine that regular small fixed payments to a medical scheme would make intuitive sense, as opposed to the rare but devastating high out-of-pocket payments required when illness strikes. However, as described in Section 4, the current legislation is responsible for a number of unintended consequences that limit the number of individuals enrolled in private medical schemes.

... current legislation is responsible for a number of unintended consequences that limit the number of individuals enrolled in private medical schemes.

Based on mid-year population estimates, the number of individuals covered by medical schemes, relative to the total population, remains low. This figure has declined from 17.0 per cent in 1994 to 14.9 per cent in 2005, and to 13.7 per cent in 2006.[28] Disaggregating this data, we gain some perspective on the number of beneficiaries[29] per age group (see Figure 11). The group with the least amount of coverage occurs in the 20-29 year age cohort, where approximately 10 per cent of people are covered by medical schemes. The number of beneficiaries covered in the lower age groupings 0-9 years and 10-19 years is 11.3 per cent and 11 per cent respectively. The age group with the largest coverage is the 40-49 years cohort where roughly 22 per cent of the population is covered by medical schemes.

Figure 11: Medical scheme coverage by age group



Source: General Household Survey, July 2006

Table 2 provides disaggregated data, illustrating the trends in medical scheme beneficiaries between 2006 and 2007. With regards to open schemes, it can be seen that the number of dependents declined by 114,860, which equates to a drop of 3.9 per cent. The number of principal members increased marginally by 15,739, which equates to 0.7 per cent. As a

Table 2: Distribution of beneficiaries in registered medical schemes

Scheme Type		2006	2007	% change
Open	Members	2,099,247	2,114,986	0.7
	Dependants	2,951,191	2,836,331	-3.9
	Beneficiaries	**5,050,438**	**4,951,317**	**-2.0**
Restricted	Members	886,103	1,063,941	20.1
	Dependants	1,190,802	1,462,782	22.8
	Beneficiaries	**2,076,905**	**2,526,723**	**21.7**
Consolidated	Members	2,985,350	3,178,927	6.5
	Dependants	4,141,993	4,299,113	3.8
	Beneficiaries	**7,127,343**	**7,478,040**	**4.9**

Source: Council for Medical Schemes Annual Report, 2007-08

whole, over the period, open schemes lost 99,121 beneficiaries. In contrast, restricted schemes have increased their numbers appreciably, albeit from a lower base. The numbers of principal members have increased by 177,838 (20.1%) and the number of dependants by 271,980 (22.8%).[30]

When one analyses the consolidated data, there were an additional 350,697 beneficiaries in medical schemes, equating to an increase of approximately 5 per cent. The numbers of principal members and dependents increased by 6.5 per cent (193,577) and 3.8 per cent (157,120) respectively.[31]

The dramatic growth in the numbers of beneficiaries in restricted schemes can largely be attributed to the Government Employees Medical Scheme (GEMS), which, as the name suggests, is restricted to government employees only. GEMS came into operation on 1 January 2006, and since July 2006, the government has offered its employees an economic incentive to join the scheme in the form of a higher contribution subsidy.

Not surprisingly, the number of individuals in GEMS swelled dramatically after the subsidy was introduced. At the end of 2006, GEMS had 44,602 principal members and 121,023 beneficiaries. By the end of 2007, the numbers had shot up to 197,082 principal members (341.9%) and a total of 539,874 beneficiaries (346.1%).[32] Arguably, the introduction of GEMS has further entrenched the directive of the government to move towards a social health insurance type system, as discussed in Section 7.

The move to increase the number of individuals covered by private medical schemes should be welcomed by all. However, the subsidy offered by government to its employees, which covers two-thirds of an individual's contributions up to a maximum of R1,014, has to be paid by someone. That someone is the small group of taxpaying individuals that comprise the tax base in SA. In Section 5 it is argued that tax deductions, rather than employer subsidies, should be used as a vehicle to retain and increase the number of individuals enrolled in private medical schemes.

Government employees, who began their service after June 2006, are compelled to join GEMS if they want to access the subsidy. New government employees will not qualify for the subsidy if they join open schemes. The subsidy is drawing a significant

number of individuals out of open schemes. According to Global Credit Ratings (GCR), of the 24 open schemes it surveys, 28 per cent of the members, in 2005, were government employees. By 2008, this percentage had dropped to 22 per cent.[33] The GEMS policy thus has the unfair advantage of having government acting as both player and referee in the market. The government plan is likely to artificially under-price open medical schemes through the use of the subsidy being paid by taxpayers. Since the government acts as regulator, pricing and tax authority, it could use these levers to favour its plan.

Table 3 below provides a general representation of the changes in medical scheme membership since 2000. Over the period 2000-2007, an additional 748,500 individuals became medical scheme beneficiaries. Over the period 2002-2003, the number of individuals enrolled in private medical schemes, both open and closed, declined. This period was followed by modest growth in the open schemes and a further decline in the closed schemes. In 2005 and 2006, the open scheme market recorded healthy growth then arguably retarded by the introduction of GEMS in 2006.[34]

Section 4 introduces the legislation currently governing the SA medical schemes market. The government has argued, "Following the implementation of the Medical Schemes Act… the central thrust of all these provisions was to ensure that the private sector could play a complementary role to the public sector".[35] Thus, one could assume that the objective of the Act was to encourage more individuals to join medical schemes in order to reduce the burden on the public sector. Indeed, the Director of Social Health Insurance, Brenda Khunoane, stated that the SA government's goal is to enable those who can afford to pay for access to health care to do so, making it possible for limited public resources to be focussed on those who cannot afford to pay.[36]

However, in Section 4, it is argued that a number of conflicting social and efficiency objectives prevent the private health insurance market from functioning effectively. Far from increasing the number of individuals enrolled in private medical schemes, these obstacles contribute to stagnation and in actual fact could cause members to leave schemes in the future.❐

Table 3: Number of beneficiaries in registered medical schemes

Year	Open	% change	Closed	% change	Consolidated	% change
2000	4,676,099		2,053,441		6,729,540	
2001	4,768,076	1.97	1,996,324	-2.78	6,764,400	0.52
2002	4,731,211	-0.77	1,982,923	-0.67	6,714,134	-0.74
2003	4,718,797	-0.26	1,953,004	-1.51	6,671,801	-0.63
2004	4,755,303	0.77	1,907,260	-2.34	6,662,563	-0.14
2005	4,905,552	3.16	1,930,069	1.20	6,835,621	2.60
2006	5,050,438	2.95	2,076,905	7.61	7,127,343	4.27
2007	4,951,317	-1.96	2,526,723	21.66	7,478,040	4.92

Source: Council for Medical Schemes Annual Report, 2007-08 and author's calculations

4. The Legislation Governing South African Medical Schemes

In terms of Chapter 1 of the Medical Schemes Act (131 of 1998),[37] the "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution[38] –

(a) to make provision for the obtaining of any relevant health service;
(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
(c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

The main aim of the Act of 1998 was to extend the cover enjoyed by beneficiaries as well as increase the number of beneficiaries. To achieve these goals, the Act made sweeping changes to existing legislation. Four main changes were introduced, namely, open enrolment, community rating, statutory solvency requirements, and the introduction of a comprehensive package of hospital and outpatient services that all schemes are compelled to provide – referred to as prescribed minimum benefits (PMBs).

Open enrolment is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). In order to reduce the probability of selecting high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining a scheme for the first time. The Act made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health, a practice commonly referred to as community rating. The Act also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds that each scheme should hold as a reserve. Finally, the Act of 1998 made it compulsory for every scheme to provide PMBs.[39]

4.1 Community rating and open enrolment

Under the Medical Schemes Act of 1967, community rating was legislated, that is the practice whereby all insurers are forced to charge the same price to every member of a scheme regardless of age, sex or health status, which meant that a 65-year old individual was charged the same premium as a 25-year old. An older person is charged less than actuarially necessary to pay their expected health care costs while a young person is charged more than is actuarially necessary. Under this system, healthy people are charged more so that sick people can be charged less.

This so-called act of 'social solidarity' has the effect of driving lower-income and healthy people out of the market or preventing them from even entering the market. The consequence is that the risk pool of insured people becomes smaller and less healthy, driving up contribution levels and making health insurance unaffordable. This vicious cycle could eventually lead to a situation where the entire health insurance market could disappear altogether.

An older person is charged less than actuarially necessary to pay their expected health care costs while a young person is charged more than is actuarially necessary.

In 1989, the medical schemes industry was deregulated and the Act of 1967 amended to allow risk rating to be used in the management of private medical schemes. To maintain the attractiveness of the risk pool to different segments of the population with different expected costs, health coverage providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. In cases where the individual is paying the full premium for coverage, health coverage providers will charge a higher premium to people who are older to recognise the higher expected costs. People seeking health insurance could therefore pay premiums commensurate with their expected health risks.

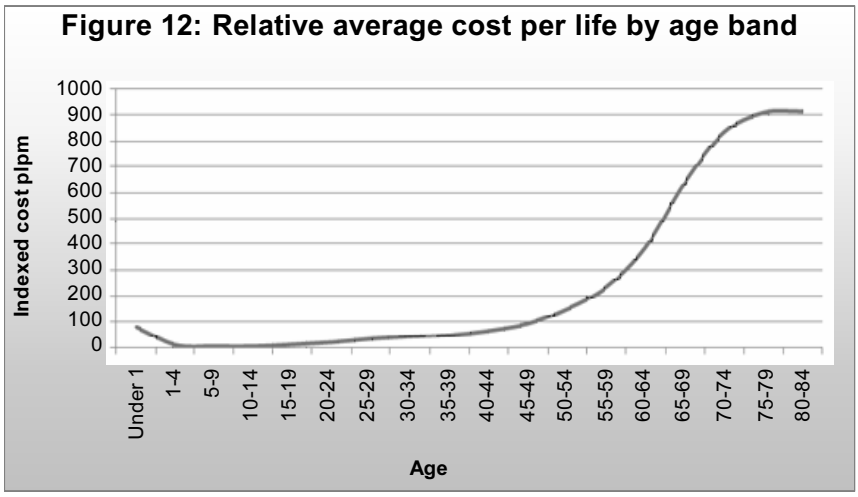
With risk rating, the responsibility for an individual's health is placed directly in their own hands, whereas the theory of social solidarity, in practice, is neither efficient nor effective. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older people with higher expected costs, raising the average cost and making coverage in the pool less attractive to younger people. The practise of selecting high-risk individuals is commonly referred to as adverse selection.

For obvious reasons, people who know that they are in poor health, are more likely to seek health insurance than people in good health. A pool subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to rise continually until the scheme becomes unviable and everyone in the scheme loses out – a process commonly referred to as the 'death spiral'.

In 1998, the SA government reverted to a system of community rating with open enrollment and introduced statutory solvency requirements and prescribed minimum benefits. Open enrollment further exacerbates the problems of community rating by making it compulsory for medical schemes to accept high-risk individuals, yet compelling them to charge the same premium as they charge low-risk individuals. It should be noted, however, that in order to accommodate the risks involved with the adverse selection of high-risk individuals, medical schemes are allowed to apply waiting periods and penalties to members over a certain age joining a medical scheme for the first time. But this merely acts as a 'band aid' to overcome the much wider shortcomings of the community rating system.

According to industry sources, the following graph (see Figure 12) gives some idea of what premiums would be like if the community rating restrictions were lifted. As noted previously, expenditure on health care is predominantly determined by age. The graph depicts the relative cost for various age groups. In general terms, an 80-84 year old individual has monthly average costs about nine times those of a 45-49 year old. Similarly, a 5-9 year-old individual has a cost of about 3 per cent of the total costs that a 45-49 year old individual can expect to pay.

When one considers SA's aging demographic profile, it is difficult to imagine how a system based on community rating could be considered sustainable. Victor Crouser, head of health care for the coastal region at Alexander Forbes, notes how age can affect insurance markets. "For every year that the average age of your scheme's membership is older than that of the average for all schemes, you can expect claims to be two percent higher than the industry average. This would in all likelihood involve higher contributions."[40]



Source: Various industry sources

The average costs of premiums therefore can be expected to rise as the population ages in order to reflect the changing demographic profile. This may cause individuals at the margin to drop out of schemes or act as a de facto barrier preventing young individuals from entering schemes and have the unintended consequence of raising the risk profile of the scheme, leading to the death spiral.

In the absence of community rating, individuals will pay premiums commensurate with their risks. When people take responsibility for their own lives, private medical schemes will be in a position to offer positive incentives such as reduced premiums or special discounts for members and policyholders who exercise regularly drink in moderation, or do not smoke, etc. Similarly, private health insurers could create negative incentives or sticks by charging higher premiums to policyholders who smoke, drink excessively and are obese.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. Government should not lock people into a pre-conceived notion of what is currently regarded as ideal. Changes will occur over time and, as the population ages, premiums will be forced to rise.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable.

4.2 Prescribed minimum benefits

Prescribed minimum benefits (PMBs) are minimum benefits which, by law, must be provided to all medical scheme members, regardless of which option they are enrolled in and include the provision of diagnosis, treatment and care costs, commonly referred to as Diagnosis and Treatment Pairs (DTP).[41] Initially,

PMBs consisted of a basket of 271 conditions, mostly hospital based, which had to be funded in full by medical schemes. In 2001, the Act of 1998 was amended and a further 26 chronic conditions were added to the list of PMBs.[42] The Council for Medical Schemes notes, "By making these benefits mandatory, the government… hopes to stamp out attempts by schemes to rate members on the financial risk they pose to a scheme because of the state of their health".[43]

By forcing medical schemes to provide a comprehensive package of minimum benefits, the PMB regulation attempts to stop risk selection through product design. Policies that predominantly cover accidental risks, tend to appeal to younger people and policies covering mainly chronic conditions, tend to appeal to older people. However, the government's list of PMBs applies to all individuals regardless of age, sex or health status and whether or not they actually need the cover. Not surprisingly, these minimum benefits raise the predicted costs of every option, thus reducing the probability of people seeking private medical coverage at the low end of the market and causing people at the margins to leave schemes. As a result of PMBs, medical scheme actuaries are prevented from devising schemes to suit particular categories of members and circumstances, and, especially important, when establishing schemes that cater for low-income people, to limit costs.

Medical scheme administrators are compelled to guard the interests of all the members of medical schemes ...

Furthermore, according to the Board of Healthcare Funders, the intended purpose of PMBs is "to ensure that members of private medical schemes would not run out of benefits for certain conditions and find themselves forced to go to state hospitals for treatment".[44] Members of medical schemes do not simply 'run out of benefits'. Contributions made by medical scheme members cover a defined list of benefits, as set out in the agreement with the medical scheme. Indeed, the Act defines a contribution as, "A consideration of money payable by or on behalf of a member to a medical scheme in exchange for medical benefits payable in accordance with the rules of the medical scheme in respect of a particular benefit option".[45]

Medical scheme administrators are compelled to guard the interests of all the members of medical schemes by ensuring that in carrying out their administrative duties they adhere strictly to the terms of the contracts between the individual members and their medical schemes. If they routinely pay for treatments that fall outside the ambit of the contracts, they will end up bankrupting the medical schemes and failing in their duty to the entire pool of scheme members.

PMBs act as a de facto entry barrier because they prevent actuaries from designing low-income insurance packages. When benefits are determined politically, rather than by what individuals want, the benefit package and the costs required to cover them expand. The consequence is that low cost medical schemes that cover the specific basic needs of low-income people cannot be designed accordingly. To increase the number of beneficiaries covered and to

reduce the cost of medical scheme options, government needs to remove PMBs. Alternatively, it could allow certain schemes at the low end of the market to be exempted from PMBs to allow actuaries to devise options that cater for low income individuals.

4.3 Statutory solvency requirements

The SA government introduced statutory solvency ratios for medical schemes in the Medical Schemes Act of 1998. Statutory solvency ratios are used to indicate the financial health of medical schemes. Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25 per cent of gross annual contributions.[46] The Council for Medical Schemes (CMS) notes, "These 'minimum accumulated funds' are more commonly referred to as the 'reserves' of a scheme".[47] When expressed as a percentage of gross contributions, this is known as the 'solvency ratio' of a scheme. The solvency level of a medical scheme is defined as, "The accumulated funds (excluding the revaluation reserve) divided by gross annual contributions in respect of a particular accounting period".[48]

This legislation was enacted to prevent a scheme from going insolvent should it experience an unusually high number of claims and record an operating loss in a particular period. But the formula for calculating the current solvency ratio was arbitrarily decided with no regard to the implications for the functioning of medical schemes. The solvency requirements were set at a level of 10 per cent when they were introduced in 2000, and have since been increased by incremental amounts to the current level of 25 per cent, which has been effective since 2004. (See Table 4.)

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions.[49] Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

A scheme that has reserves below the legislated 25 per cent minimum requirement will have trouble 'catching up' because new members will be in the invidious position of having to contribute not only towards their own portion of the required reserves, but also towards making up past shortfalls, a cost for which they will receive no benefit. Despite the intentions of the SA government to prevent schemes from failing, the solvency requirements will increase contributions, which, in turn, will adversely affect the number of individuals covered by schemes.

According to the CMS, the average solvency ratio of open schemes was 28.6 per cent in 2007. However, in the same year18 of the open schemes fell below the required solvency ratio of 25 per cent and these 18 schemes accounted for approximately 63 per cent of beneficiaries. In fact, since the solvency requirement was introduced in the year 2000, the number of beneficiaries in schemes that fall below the prescribed level has been consistently above 50

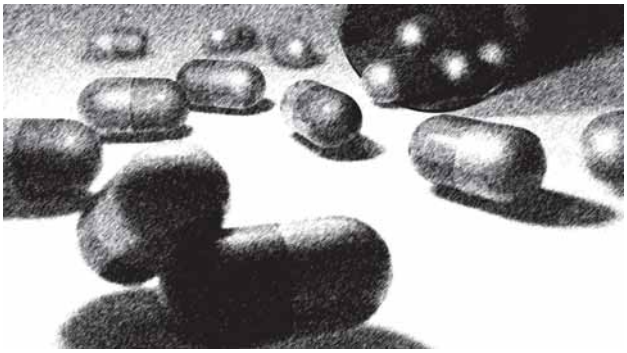
per cent of the total number of beneficiaries of all open schemes (see Table 4). In other words, since the solvency requirements were introduced, more than half of all open scheme beneficiaries have been in schemes that, according to the regulations, are deemed financially unstable.

Table 4: Prescribed solvency levels, schemes and beneficiaries[50]

Year	Prescribed level		Number of schemes below prescribed level	Number of beneficiaries below prescribed level	% of beneficiaries below prescribed level
2000	10.0%	Open schemes	15	2,385,051	51.0%
		Closed schemes	15	839,029	40.9%
2001	13.5%	Open schemes	19	2,650,934	55.6%
		Closed schemes	11	576,462	28.9%
2002	17.5%	Open schemes	24	3,519,329	74.4%
		Closed schemes	7	251,050	12.7%
2003	22.0%	Open schemes	19	3,426,988	72.6%
		Closed schemes	7	222,430	11.4%
2004	25.0%	Open schemes	18	2,534,273	53.3%
		Closed schemes	4	80,160	4.2%
2005	25.0%	Open schemes	17	2,783,108	56.7%
		Closed schemes	4	36,359	1.9%
2006	25.0%	Open schemes	18	3,218,382	63.7%
		Closed schemes	4	145,369	7.0%
2007	25.0%	Open schemes	18	3,139,176	63.4%
		Closed schemes	7	689,865	27.3%

Source: Council for Medical Schemes Annual Report, 2007-08

Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.



Under the community rating system, schemes need to attract new young members constantly in order to cross-subsidise the older members in the scheme. If this is not done, the average age in the pool will increase and the average premium will have to rise commensurately. The solvency ratios of schemes that are growing are placed under pressure because if a scheme's membership increases rapidly, its contribution income has to rise steeply.

As noted previously, a scheme's solvency ratio is determined from the reserves as a percentage of the contributions. If the contributions increase without a similar increase in the reserves, the solvency ratio will decrease. For example, consider the case of GEMS, which grew by 346.1 per cent over the period 2006-2007. In 2006, GEMS had a solvency ratio of 36.6 per cent. By 2007, this plummeted to 8.4 per cent, which equates to a decline of 77.1 per cent. The average age in GEMS was a mere 26.3 years and it had a pensioner ratio (65 years+) of 2 per cent at the end of 2007. Compare this to the total market with an average age of 31.4 years and a pensioner ratio of 6.2 per cent.[51]

Solvency requirements are a barrier to entry for new medical schemes trying to enter the private medical schemes market. It is unreasonable to expect potential entrants to raise enough capital, not only to fund their daily activities, but also to meet the statutory solvency requirements. With our aging population and the barriers to entry in the market, we could reasonably expect to see substantial consolidation of existing medical schemes.

The consequences of the barriers created by statutory solvency requirements are entirely predictable. According to the CMS, in 2002 there were 143 registered medical schemes, but by the end of 2006 this number had declined by 13.3 per cent to 124. The CMS notes, "The decline in the number of medical schemes was due to amalgamations and liquidations. Some of the motivations cited by schemes upon amalgamation or liquidation were low membership, poor long-term financial sustainability, low economies of scale and difficult trading conditions".[52]

The statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones. This is not a desirable situation given the substantial expected future demand for health care in the country.❐

5. Tax Deductions & Exemptions

It has been proposed that tax deductions on medical scheme contributions be eliminated because they are viewed as a subsidy to the rich. However, eliminating these tax deductions will have the effect of driving up the cost of medical scheme contributions, causing those at the margin to drop out and making it unaffordable for new members to join medical schemes. Furthermore, it should be noted that if the proposal to introduce a National Health Insurance (NHI) system in SA went ahead (discussed in Section 7), contributions towards medical schemes will be over and above the amount deducted through general taxation and compulsory contributions to fund the proposed NHI style system.

A tax deduction makes the purchase of insurance more affordable by reducing an individual's tax liability. Medical scheme contributions are tax deductible but in the 2009/10 tax year they are limited in the first instance to a maximum of R625 per month for a single contributor, R1,250 for the principal member and one dependant and R380 per month for each additional dependant. Furthermore, all allowable medical expenses and medical scheme contributions that exceed the above limitations are tax deductible to the extent that they exceed 7.5 per cent of taxable income. For example, if an individual's taxable income is R200,000, the additional deductible amount will be for expenses exceeding R15,000 (7.5% of R200,000). If a married person under the age of 65 with no children had unrecovered spending on medical expenses and medical scheme contributions in excess of the maximum permissible deductions described above of, for example, R16,000, they would be entitled to deduct contributions of R1,250 x 12 = R15,000 + R1,000 (R16,000 – R15,000) = R16,000.

It should be noted that the above is a deduction from taxable income and not a subsidy from government as some commentators have suggested. In the case of subsidies, someone has to pay. Whenever government offers a subsidy, it is the taxpayers who have to foot the bill. So even when government offers a subsidy to its employees to join its preferred medical scheme, this is paid for by taxpayers.

The SA government wants a healthy and productive workforce. Given the amount of out-of-pocket expenditure on health in SA, private health insurance coverage could be extended to a greater proportion of the population if affordable premiums can be made available. Rather than forcing individuals to purchase cover, the government should allow the market to function efficiently. Tax deductions are an option, but removing the statutory requirements that artificially inflate the cost of insurance is surely the first problem to be addressed in efforts to reduce the overall cost of obtaining private medical insurance.❐

6. South Africa's Health Care Brain Drain

A significant issue facing the SA healthcare sector is the dramatic decline in skilled healthcare personnel.[53] Information from SA medical schools suggests that one third to one half of their graduates leave this country to seek work in the developed world.[54] SA's chronic shortage of skilled healthcare professionals continues unabated and the situation worsens by the day. Despite this, the Department of Health continues to restrict the supply of doctors by limiting the number of foreign health professionals entering SA and the number of positions available at the eight government-run medical schools across the country.[55]

The number of places available to train doctors is determined by the Health Professions Council of South Africa (HPCSA)[56] and is limited to approximately 1,300 positions each year (see Table 5).[57] This situation has remained relatively unchanged since the 1970's despite the fact that the demand for these positions increases every year. In 2006, it was estimated that 15,794 prospective students applied for these coveted positions.[58]

The outputs from the medical schools over the same period can be viewed in the table Outputs at Medical Schools 1994 to 2005 below (see Table 6). Out of the 17,231 individuals admitted to the schools, 14,817 graduated, indicating an 86 per cent pass rate. According to HPCSA, despite the fact that medical schools produced approximately 19,500 graduates between 1990 and 2005, the register of HPCSA only showed 9,304 new registrations during this period.[59] This implies that a significant number of individuals are graduating but, instead of practising in SA, are leaving the country.

According to a study conducted by the OECD in 2003 entitled 'South African born workers, practising a medical profession in certain OECD member countries in 2001', "Despite substantial financial incentives, many commentators, including some employee representatives, emphasise that in many cases pay is not the prime motive for leaving the country. Deteriorating working conditions in the public sector is one factor that is frequently mentioned. A signifi-

Table 5: Admissions to Medical Schools 1994 to 2005

Institution	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
UCT	188	190	182	188	201	183	203	210	201	198	200	200	2344
Free State	140	117	128	100	103	91	90	145	139	150	131	137	1471
MEDUNSA	369	222	182	235	234	180	251	318	199	171	221	239	2821
Natal	123	127	160	149	194	195	199	197	199	211	212	206	2172
Pretoria	235	224	231	208	182	178	207	226	229	222	241	232	2615
Stellenbosch	163	157	172	188	185	204	194	191	201	218	213	222	2308
UNITRA	41	38	62	63	64	72	91	95	108	115	109	105	963
WITS	220	204	254	216	209	220	248	266	168	154	172	206	2537
Total	**1479**	**1279**	**1371**	**1347**	**1372**	**1323**	**1483**	**1382**	**1276**	**1285**	**1327**	**1341**	**17231**

Source: National Department of Education, 2005

Table 6: Outputs at Medical Schools 1994 to 2005

Institution	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
UCT	167	149	152	147	170	186	132	166	166	164	159	152	2344
Free State	88	87	87	109	117	110	119	124	107	97	111	70	1226
MEDUNSA	123	155	183	249	264	325	247	264	304	326	294	325	3059
Natal	90	109	101	110	104	114	90	116	132	165	179	334	1168
Pretoria	165	173	193	203	217	202	209	214	192	207	196	209	2380
Stellenbosch	157	170	174	158	148	150	145	142	136	186	156	162	1884
UNITRA	18	26	26	29	31	*	26	53	51	62	120	78	520
WITS	202	213	190	228	195	*	195	192	181	188	205	247	2236
Total	**1010**	**1082**	**1106**	**1233**	**1246**	**1087**	**1163**	**1079**	**1088**	**1207**	**1215**	**1330**	**14817**

Source: National Department of Education, 2005

cant increase in the workload, due to wider access to health care, and the uneven distribution of human resources between the private and public sector, and urban and rural areas, leads health professionals to seek better working conditions. Exposure to AIDS and other endemic infectious diseases, like TB, insecurity resulting from delinquency, the lack of suitable equipment, and social and racial factors, also are cited as difficulties that specifically affect the practice of medicine".[60]

An immediate response to alleviate the chronic shortages of medical personnel would be to let skilled foreign health professionals practise in SA. However, according to the National Human Resources Plan for Health, the government has set the ill-conceived target of a maximum of 5 per cent of SA's medical workforce to consist of foreign doctors.[61] It is estimated that currently 15 per cent of the workforce is foreign. Compare this to the United States where it is estimated that 27 per cent of practising doctors are trained abroad.[62] The majority of foreign doctors in SA work in rural areas – without them the rural system would be sure to collapse. Although there is not a specific estimate of what it costs the government to put an individual through medical school, the general consensus is that it is in the region of R2-million per doctor. In contrast, it costs approximately R100,000 to recruit a foreign doctor.[63]

SA has taken the stance that, "No active recruitment for permanent employment in South Africa will be directed at other developing countries in the African region".[64] Although the attempt to restrict the flow of health professionals from our fellow African neighbours is well intentioned, OECD countries and other struggling developing countries will be more than happy to absorb these available health professionals into their systems,[65] and SA's patients will be the ultimate losers.

The government not only restricts entry for foreign doctors but also places various other restrictions and conditions on their terms of employment. Foreign doctors and other health professionals may only work for a period of three years or less and those who do not enjoy permanent resident status are not permitted to enter private practice.[66]

The shortage of trained medical personnel is not limited to SA. The World Health Organisation estimates that there is a worldwide shortage of 4.3 million health

workers.[67] Rather than acknowledging the worldwide shortage, SA's ex-Minister of Health, Manto Tshabalala Msimang, stated, "Rich countries should not undermine the health systems of poor countries by poaching their workers. The continued illicit recruitment of health workers by the developed countries should stop".[68] The free movement of labour is a fundamental and inalienable right of individuals. Doctors and nurses who decide to leave their homes to work elsewhere cannot be blamed for the situations they leave behind.

The government's response to address the skills shortages has been to increase substantially the remuneration of public health sector professionals. Although this may sweeten the conditions for existing professionals working in that sector, it does not address the root cause of the problem sufficiently, namely, the need to increase the supply of doctors. Moreover, SA is in no position to win a bidding war against developed nations for these scarce resources.

A long-term strategy to alleviate the chronic staff shortages requires the government, and more specifically, the Department of Education, to relax the controls on tertiary education facilities, make entrance to these facilities less restrictive, and allow the private sector to provide a large percentage of tertiary medical education for doctors. If private education facilities are established they could operate on either a for-profit or non-profit basis and would have the potential to relieve a significant part of the burden currently faced by the public sector.

Consider the progress that has been made in the training of nurses. With the closure of many of the public sector nursing colleges in the 1990's, severe shortages ensued. According to a discussion document tabled in SA's Parliament, a total of 2,629 registered nurses graduated from these public sector facilities in 1996, ten years later this figure plummeted to 1,493.[69] But the private hospital sector in SA has been investing significantly and intensively in both the financing and training of nurses to try and fill the gap. According to the South African Nursing Council, in 2006 the private sector funded and trained approximately 54 per cent of the registered nurses who qualified in SA.[70]

If the government allowed the private sector to train doctors and stopped artificially restricting the supply of skilled health professionals, the situation could improve. As noted previously, SA's private hospitals are well-established centres of excellence and world-renowned for their high levels of care. Privately run education facilities, if conducted in co-operation with private hospitals, have the potential to attract internationally recognised lecturers, which will increase the available pool of knowledge, as well as international students, who will be prepared to remain and work in SA. Privately run medical schools will not solve the chronic medical staff shortage overnight, but will assist the government's long-term efforts to increase the number of medical professionals in SA.❐

If the government allowed the private sector to train doctors and stopped artificially restricting the supply of skilled health professionals, the situation could improve.

7. Is a National Health Insurance System Appropriate for South Africa?

As far back as 1944, the SA government considered the idea of introducing a fully tax-funded National Health Service (NHS) or National Health Insurance (NHI) with the ambitious target of providing free health care for all South Africans.[71] The policy was never adopted, primarily due to a lack of funding. More than 60 years later, this ambitious goal is still not a feasible option. The SA average per capita income continues to languish at approximately US$5,162 (R32,830) per annum,[72] a figure that masks substantial income differences compounded by unemployment levels that vary between 23 and 36 per cent, depending on which measure of unemployment is adopted.[73]

When citing the case for a NHI, many advocates refer to Norway, Canada, Ireland and Singapore. However, these countries are poor examples for comparison because all of them have significantly higher GDPs per capita, higher rates of employment and vast amounts of healthcare resources relative to SA. Yet, despite these endowments, Canada and the United Kingdom, where average per capita incomes are $35,133 (R223,447) and US$37,266 (R237,012) respectively, are struggling to meet the demands of their patients under their 'free care for all' systems.[74] The results of 'free care' are long waiting times and increased pressure on health workers with the ensuing sub-standard levels of care.[75] However, with the introduction of the Medical Schemes Act of 1998, the government has slowly begun to lay the foundations for a mandatory social health insurance (SHI) system.

As noted by McLeod and Ramjee (2007), "Since 1994 there has been a substantial return to solidarity principles although medical schemes still operate in a voluntary environment. The fully re-written Medical Schemes Act, No 131 of 1998, which has been applicable since 1 January 2000 has prepared the environment for Social Health Insurance".[76]

The Department of Health has also made it clear that a SHI system is simply a stepping-stone towards a NHI system.[77] The idea of introducing a fully tax-funded NHS or NHI with the ambitious target of providing free health care for all SA citizens has been gaining momentum in recent years. According to the ruling party's latest election manifesto: "The ANC government will: …introduce the National Health Insurance System (NHI) system, which will be phased in over the next five years. NHI will be publicly funded and publicly administered and will provide the right of all to access quality health care, which will be free at the point of service…".[78]

The main difference between SHI and NHI are that the former compels all formal sector employees (above the minimum tax threshold) who are not already covered by a scheme to pay on a monthly basis into the SHI fund. This targeted group of individuals is not allowed to opt out of the scheme or be excluded and their premiums are based on their incomes. Only those who contribute to the SHI fund will be entitled to a predefined list of basic benefits in addition to access to free primary health care services. A NHI system in contrast, is a universal system that covers the entire population irrespective of whether contributions are made.

When the government started implementing the Medical Schemes Act of 1998, the four main changes which it ushered in were: open enrolment, community rating, solvency requirements and prescribed minimum benefits.[79] The Department of Health's next step is to introduce a risk equalisation fund (REF) that aims to transfer money from schemes that have more low risk members towards schemes with higher risk mem-

bers – where risk is measured along several key, pre-specified dimensions.[80] Once again the REF is simply a response to the community rating system and discourages schemes from competing in the market.

... the ability and willingness of households in developing countries to pay for health care is far greater than the capacity of government to mobilise resources through taxation.

Is SA capable of providing free health care for all? Bowie and Adams (2005) suggest, "In the majority of low and middle income countries, the government cannot raise enough funds through general taxation to adequately finance the public health system and lack the institutional and organisational capacity to establish a functioning system of mandatory health insurance for the formally employed".[81] Moreover, according to Alexander Preker, lead economist at the World Bank, "The ability and willingness of households in developing countries to pay for health care is far greater than the capacity of government to mobilise resources through taxation".[82]

The government can promise free health care for all but there is no such thing – someone has to pay for it. If SA were to move towards socialised health care, the small group of individuals that comprise the tax base would be made increasingly responsible for meeting the healthcare needs of the nation. In 2007/2008, there were an estimated 5.2 million registered individual taxpayers.[83] However, it should be noted that a small minority make up a significant proportion of the total tax take. For example, in 2006, of the approximately 3.2 million taxpayers assessed, about 70 per cent (those with taxable income between R50,000 to R300,000 per year) accounted for 55 per cent of personal income tax. The bottom 21 per cent of taxpayers (with taxable income below R50,000) accounted for less than 0.5 per cent of income tax assessed while the top 7 per cent of taxpayers (with taxable income in excess of R300,000 per year) accounted for over 45 per cent of income tax assessed. (See Annexure 2.)[84]

The social safety net is being cast wider than ever before. The number of social welfare beneficiaries has increased from 2.5 million in 1999 to 12.4 million in 2008, and, according to the 2009 budget speech, it is projected to rise to over 13 million in 2009. Shortly after becoming SA's President in March 2009, Kgalema Motlanthe said having 12 million people dependent on social grants was "not sustainable… For their own dignity it's much better if people have decent jobs".[85]

SA's average per capita income of approximately US$5,162 (R32,830) per annum masks glaring inequities. It is estimated that between 23 per cent[86] and 41 per cent[87] of the population lived below the poverty line in 2007.[88,89] This is not surprising when one considers the high levels of unemployment that persist in the SA economy. According to the official government statistical agency, Statistics South Africa (Stats SA), in September 2007, 3.9 million individuals were officially unemployed. This equates to an official unemployment rate of 22.7 per cent. How-

The government can promise free health care for all but there is no such thing – someone has to pay for it.

ever, a further 3.4 million individuals did not actively search for work in the month prior to the survey but indicated that they would work if there were jobs available. If these discouraged work seekers are included, the total number of unemployed increases to 7.3 million and the unemployment rate shoots up to 35.6 per cent.[90]

In his State of the Nation Address, SA's former President, Kgalema Motlanthe said, "Many health facilities do not always have the required medicines, appropriate staffing levels, and constant supply of basic services such as clean running water and electricity. In some of these facilities, management is poor and staff attitudes need improvement".[91] When one considers the high levels of poverty and unemployment, the small tax base, and the poor performance of the public health sector, it is difficult to envision how a government-funded system that promises free care for all is appropriate for SA.

The consequences of the NHI proposal are entirely predictable. It would reduce the quantity and quality of SA healthcare provision, drive more healthcare professionals out of the country, create a bureaucracy entirely incapable of efficiently handling the huge volume of claims, and impose an unnecessary and intolerable burden on government. The resultant lack of quality health care could also have the unintended consequence of further exacerbating the brain drain as citizens move to countries where they and their children have a better chance of surviving serious illness.

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7.1 The fallacy of single payer systems

Some advocates for NHI in SA have held up the Canadian single payer system,[92] as an example for SA to follow. The reasons why a NHI will fail in SA can be found in a new Canadian study conducted by the Fraser Institute entitled: 'The Hidden Costs of Single Payer Health Insurance: A comparison of the United States and Canada'. The study compares some of the key aspects of the healthcare systems of Canada and the United States, including the supply of medical resources, access to technology and effective health insurance coverage.

According to the study, "In Canada, the government promises everyone that they have health insurance coverage for all medically necessary goods and services; but, in reality, access to treatment is often severely limited or restricted altogether".[93] The study goes on to note, "In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2007, the wait had increased to 18.3 weeks. Moreover, wait times in Canada are almost double the length that physicians consider clinically reasonable".[94]

Canadian courts have seen the evidence and ruled that Canada's single payer health insurance monopoly makes people wait too long to get medically necessary care. The Canadian single payer system is an example of what not to do in health care. The fact is that single payer systems are probably the worst way to achieve universal health insurance coverage. If Canada is currently witnessing the failure of its own single payer health insurance system, why would South Africa want to adopt such a system?

Many Canadian trained and previously active physicians have left Canada for better opportunities and working conditions in the United States. The Fraser report notes that American doctors are not voting with their feet by moving to Canada for better opportunities or working conditions. As of 2002, there were 8,990 Canadian-trained physicians (a number equal to 13% of the Canadian physician workforce) actively practising in the United States. By contrast, only 519 American-trained physicians (equal to less than 1% of the American physician workforce) were working in Canada.[95]

In order to correct the problems associated with government-run national health systems, the British NHS system is adopting a number of reforms where the private sector will play an increasing role in both financing and delivery of health care. In her paper entitled "NHS as State Failure: Lessons from the Reality of Nationalised Health Care", published in the December 2008 issue of Economic Affairs, Helen Evans, the Director of Nurses for Reform in the UK, notes, "Under the general rubric of Public Private Partnerships, the British government has championed a whole raft of market-oriented reforms".[96]

These reforms include sending NHS patients to independent hospitals and clinics for care; asking the private sector to design, build and operate a new generation of Independent Sector Treatment Centres for the benefit of NHS patients, and a plan to establish a new generation of independent Foundation hospitals free from government control with a greater say over how they develop and raise capital.[97]

More importantly, an increasing number of British people are taking responsibility for their own health care. Approximately 7-million individuals have private medical insurance; 6-million have private health cash plans; 8-million pay privately for complementary therapies, and, each year, more than 250,000 pay for their own acute surgery. In a welcome change to past legislation, seriously ill patients are now allowed to add their own money to the purchase of the most innovative medicines and treatments.[98]

Evans (2008) states, "Only by putting patients and consumers' interests first will healthcare really improve. It is only when healthcare is opened up to real consumers, trusted brands and new funding mechanisms – such as private health savings accounts – that nurses and other health professionals will find themselves working in environments with the incentives, resources and freedom to deliver responsive, popular and high quality care".[99] Evans concludes her paper by stating, "As such, I reject egalitarianism and nationalisation in favour of healthy privatisation and competition. Ultimately, 20 years working in the NHS has taught me to believe in people and markets – not political diktat".[100]

As part of her input to the 1994 Finance Committee established by the Department of Health to advise on NHI, Professor Anne Mills, Head of the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine, suc-

cinctly summed up the situation regarding the appropriateness of a NHI-style system for SA by saying, "It is clearly financially unaffordable to offer universally either the benefits currently on offer in medical aid schemes, or free and complete in the public sector. Benefits would therefore have to be severely restricted. However, it is difficult to see how this can be achieved because the setting up of a universal scheme would raise expectations about access to care. Moreover, the scheme would put in place a financing mechanism before having in place the health service infrastructure to satisfy demand. Benefits would inevitably be unevenly available, causing justifiable grievance".[101]

SA already spends a considerable amount of money on health, yet the health status of South Africans compared to people in other middle-income developing countries is relatively poor.[102] There are a number of factors that influence health status such as income, education and access to basic services such as water and sanitation. A high level of spending on health services will not, by itself, result in good health.[103] Simply pouring more money into a dysfunctional system will not solve the underlying problems.

SA's expenditure on health care has increased at a phenomenal rate since 1994, yet the results have been far from spectacular. Nearly 50 per cent of provincial budgets go towards healthcare spending.[104] The national budget for the public health sector has almost trebled from R16-billion in 1994/1995 to almost R57-billion in 2006/2007 (see Table 7). In 2007, the total public sector health budget was R59.2-billion, which constituted 3.05 per cent of GDP and 11.08 per cent of government expenditure.[105]

When you add to that increased costs, antiquated infrastructure and an aging population, it is seriously doubtful whether the government is justified in wanting to introduce a NHI style system. New investment in the health sector is an essential priority given the potential crisis, but government has a poor track record in investing and maintaining public sector infrastructure, so it is not unreasonable to assume that this investment will not be forthcoming in the future. It is essential for the private sector to continue to play a significant role in SA's health care. Considering the fact that medical schemes provide the main channel for accessing private health care, it goes without saying that legislation which impacts this sector will directly affect the private provision of health care.

Table 7: National government health spending patterns (R billions), 1995-2007

Year	Expenditure	Percentage change
1995	16.097	
1996	20.615	28.07%
1997	22.484	9.07%
1998	23.023	2.40%
1999	24.375	5.87%
2000	26.417	8.38%
2001	29.884	13.12%
2002	33.367	11.66%
2003	35.762	7.18%
2004	40.575	13.46%
2005	46.917	15.63%
2006	51.486	9.74%
2007	56.994	10.70%

Source: Akinboade et al*, 2009:149*

Under single payer models, governments inevitably impose price controls that limit the supply of medicines and access to treatment because they simply are not able to provide unlimited care to everyone. The slow and bureaucratic nature of government prevents new technologies from entering the system. Procedures are limited, as are the number of hospitals and the number of beds in those hospitals. This causes increased waiting times or millions being treated with outdated medical technologies.

Evidence from the Fraser Institute study indicates that government control over hospital financing results in the capital deterioration of the facilities.[106] Witness the decaying buildings as well as a chronic shortage of basic equipment in the majority of public hospitals in SA.[107] In view of the fact that public enterprises do not face competition, they do not have the same incentive as the private sector to modernise and maintain their facilities. In SA, it takes months, if not years, for the Department of Health to recognise the chronic shortages of equipment or health professionals, or that facilities are in desperate need of repair or renewal. Government central planners cannot make timely decisions to modernise healthcare infrastructure. By contrast, consumer choice forces private sector hospitals constantly to modernise, evolve new strategies and invest in new technologies.❐

8. Conclusion

"If you think healthcare is expensive now, wait until you see what it costs when it's free!" – US political satirist, journalist and writer PJ O'Rourke (1947-).

The purpose of this paper is to argue that the private sector remains an important feature in the SA healthcare market. Private health insurance increases access to quality care, particularly amongst those willing to pay for it and improves consumer choice, leading to greater health system responsiveness. Future healthcare reforms in SA must recognise the role of the private sector. The essential ingredients for a successful private sector are personal freedom, competition and innovation. Expanding the private health insurance sector will provide consumers with greater choice and satisfaction. And if the government allowed the private sector to train medical personnel it would help to alleviate the chronic shortage of skilled personnel.

The biggest obstacles preventing medical schemes from rolling out options for low-income individuals are the regulations put in place by government. These regulations must be amended so that individuals are free to choose plans that suit their individual needs and those that have no bearing whatsoever on their health must be scrapped. Options that are tailored for individuals, based on their specific healthcare needs, will allow those previously uncovered to obtain insurance.

Options that are tailored for individuals, based on their specific healthcare needs, will allow those previously uncovered to obtain insurance.

The government's pursuit of mandatory health insurance will be yet another tax on an already overburdened formal sector economy. Higher tax rates reduce the incentives of entrepreneurs to risk their capital or to sacrifice their time and energy. It interferes with the ability of individuals to pursue their goals because it results in lower after-tax income, and therefore smaller disposable incomes. Smaller disposable incomes mean less saving; less saving means less capital formation; less capital formation means lower labour productivity and lower labour productivity means lower real wages.

The pursuit of mandatory health insurance in SA should therefore be seen as a dubious 'second best' option given both the underlying structural problems within the healthcare sector as well as those within the general economy. National Health Insurance is no panacea. As long as South Africans remain poor, they will struggle to cover their healthcare financing requirements. The government's policy and discussion documents do not explain how SA will succeed in providing equitable health care to all through the envisaged national health system, when wealthy countries have failed in their attempts to do this. Before any plans for a NHI are proposed, it is vital that an actuarial evaluation is carried out so that the South African public know exactly what services will be offered and ultimately whether such a system would be feasible.

SA's situation is not unique. The vast majority, if not all, developing countries face the challenge of having insufficient revenues to adequately provide for the healthcare needs and demands of their entire population. Moreover, even wealthy nations fail to meet the needs of their patients under government-

controlled systems. One only has to look at the evidence from the Canadian and British systems to witness these problems.

How should government accommodate the truly destitute who cannot afford to sustain themselves let alone purchase medical care? For these individuals, government could act as financier and purchase the best possible care available. Wolvaardt et al (2008) note, "Given the fact that the majority of primary care providers still congregate in the private sector, despite numerous attempts by government to increase professional staff in the public sector, serious consideration needs to be given to outsourcing patients to the private sector. Not utilising this resource while the public sector annually shows unspent budget allocations for PHC (primary health care) services makes little sense".[108]

However, Wolvaardt et al (2008) note, "Although a number of health sector PPPs have been established and are also in the pipeline, they have not really tapped into the large capacity and ability of the private sector to deliver PHC [primary health care] services".[109] The public sector should thus seriously look at the ability of the private sector to increase service delivery to the uninsured and destitute.

Many community-based, faith-based and non-governmental organisations are capable of supplying health care. For example, Wolvaardt et al (2008) cite the United States President's Emergency Program for Aids Relief (PEPFAR) as a case in point. The authors note, "PEPFAR has demonstrated the ability of the private sector to absorb substantial amounts of money, in a responsible manner, and the ability of this sector to reach large numbers of the uninsured population".[110]

The former Secretary General of the United Nations, Kofi Annan, illustrated the potential of the private sector to reduce the burden on the public sector when he said: "The UN once dealt only with Governments, by now we know that peace and prosperity cannot be achieved without partnerships involving government, international organisations, the business community and civil society. In today's world we depend on each other".[111]

Increased competition in the market will lead to decreased costs and improve the overall healthcare options of the nation.

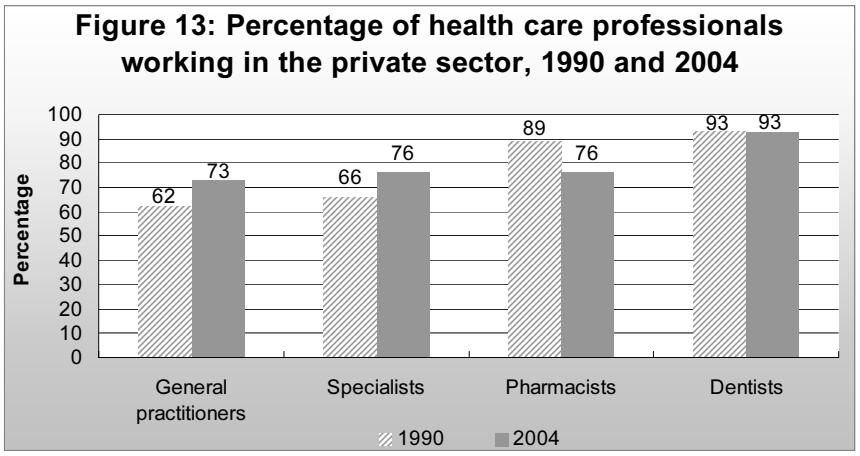
If the Department of Health genuinely has all SA's citizens' health care interests at heart, it would increase competition in the market by removing the barriers currently constraining the efficient functioning of the private provision and financing of healthcare services. Increased competition in the market will lead to decreased costs and improve the overall healthcare options of the nation. The government should therefore leave the private sector alone – let the people decide how and where they want to spend their money and concentrate on fixing the public health sector.❐

Annexure 1: Distribution of human resources in South African health care

Table 8: Distribution of healthcare professionals between the public and private sectors, 2004

	Total	**Public sector Number (%)**	**Private sector Number (%)**
General practitioners	19,729	5,398 (27.4%)	14,331 (72.6%)
Specialists	7,826	1,938 (24.8%)	5,888 (75.2%)
Dentists	4,269	316 (7.4%)	3,953 (92.6%)
Pharmacists	4,410	1,047 (23.7%)	3,363 (76.3%)
Psychologists	3,808	222 (5.8%)	3,586 (94.2%)

Source: Van Rensburg, 2004 in South African Health Review*, 2008*



Source: National Department of Health, 2006 in South African Health Review*, 2008*

Annexure 2: Taxable Income & Tax Assessed by Taxable Income Group, 2003-2006

Table 9: Taxable income & tax assessed by taxable income group, 2003-2006

	2003 (95.1% assessed)			2004 (92.3% assessed)			2005 (87.0% assessed)			2006 (71.0% assessed)		
Taxable income group	Number of taxpayers	Taxable income (R million)	Tax assessed (R million)	Number of taxpayers	Taxable income (R million)	Tax assessed (R million)	Number of taxpayers	Taxable income (R million)	Tax assessed (R million)	Number of taxpayers	Taxable income (R million)	Tax assessed (R million)
R0 to R50,000	1,049,595 (31.31%)	9,161 (2.75%)	908 (1.15%)	1,010,068 (28.52%)	8157 (2.14%)	625 (0.76%)	931,917 (25.85%)	6,617 (1.56%)	457 (0.5%)	696,306 (21.66%)	7,351 (1.77%)	262 (0.3%)
R50,001 to R300,000	2,158,184 (64.38%)	242,584 (72.89%)	50,414 (63.53%)	2,348,231 (66.3%)	272,106 (71.33%)	48,409 (58.58%)	2,449,458 (67.94%)	293,583 (69.11%)	50,855 (55.25%)	2,292,570 (71.30%)	284,998 (68.58%)	46,911 (54.42%)
>R300,000	144,411 (4.31%)	81,058 (24.36%)	28,026 (35.32%)	183,707 (5.19%)	101,193 (26.53%)	33,606 (40.67%)	224,003 (6.21%)	124,612 (29.33%)	40,731 (44.25%)	226,316 (7.04%)	123,200 (29.65%)	39,034 (45.28%)
Total	**3,352,190 (100%)**	**332,804 (100%)**	**79,350 (100%)**	**3,542,006 (100%)**	**381,457 (100%)**	**82,641 (100%)**	**3,605,378 (100%)**	**424,813 (100%)**	**92,045 (100%)**	**3,215,192 (100%)**	**415,551 (100%)**	**86,208 (100%)**

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Jasson Urbach analyses the effects of changes in South Africa's medical scheme legislation and regulations that have occurred during the past decade and discusses the potential consequences of recently proposed further changes.

The author argues that these policies involve a conflicting mix of social and efficiency objectives that are likely to have dramatic and far-reaching implications for the delivery of health care.

He argues that a poor developing country such as South Africa would not be able to sustain a nationalised system of health care given the increasing burden on the small tax base, the antiquated infrastructure within the public health sector, the country's aging population, the inevitable increased demand that will arise from promised "free" health care, the inadequate number of medical personnel being trained, and the loss of skilled personnel to other countries that will probably accelerate if a NHI system is adopted.

He proposes that if government instead were to amend the legislation to remove prescribed minimum benefits, community rating and open enrolment, and revise the statutory solvency requirements, medical scheme actuaries would be able to devise schemes to suit a much larger percentage of the population, including those with low incomes. He also points out that the private health insurance market would have a significant role to play in alleviating the burden on the public sector by increasing the number of individuals enrolled in private medical schemes. And the skills shortage would be alleviated if government were to relax the restrictions on foreign skilled medical personnel entering and practising in South Africa and allow the private sector to train prospective students.

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