Feature Article

National Health Insurance – An Introduction

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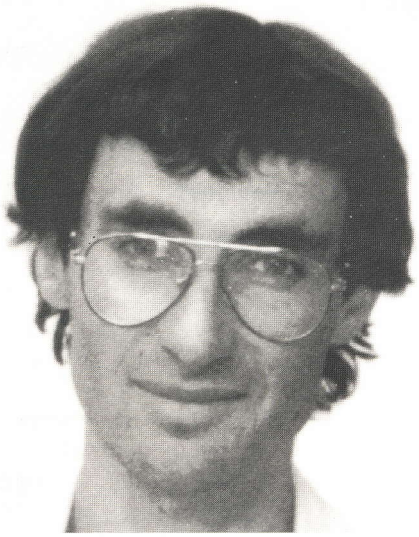

Curriculum Vitae

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Dr Blecher qualified at the University of Witwatersrand in 1983. He worked for several years at community health centres in Crossroads and Duncan Village and in the Unit of Family Medicine/ Primary Care, University of Cape Town. He is currently based in the Department of Community Health and wrote this article while in its Health Economics Unit. His qualifications include MBBCh, MFGP (SA), MPhil(MCH) and Dip Obst(SA). His interestse include the financing and provision of primary health care. He is married to Salma and they have two children.

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Summary

National Health Insurance (NHI) is a system of financing health care on a large scale. Membership tends to be required by law for everyone employed in the formal sector but contributions are usually income-related in order to make them affordable to all employees. NHI is increasingly being considered as an option in South Africa. Potential advantages include increasing financial resources for health, improving access for workers to GP services and relieving the public sector so that it can expand primary health care in the most needy areas. Risks include inappropriately directing more resources into highly technical, specialised and hospital-based care.

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KEYWORDS

National Health Programs; National Health Insurance, Non - US; Physicians, Family; Financing, Public.

NHI is increasingly being considered for RSA.

Introduction

As we rapidly move into a period of transition in South Africa, various options for future systems of health care delivery are being debated. A major influence on the way health care is provided is the way in which it is financed. One financing mechanism which is increasingly coming under the spotlight is National Health Insurance (NHI, also called social health insurance), the possibility of which has been raised by many including the African National Congress[1], the current government[2] and academics.[3,4,5,6,7] Although NHI is one of the major options of health financing available for South Africa,

many practitioners are not familiar with the concept. This article attempts to introduce and summarise some of the key issues.

National Health Insurance is one of the most common forms of financing health care world-wide. At last count 87 countries had social insurance schemes including many developed countries (much of Europe, Australia, Canada) and a considerable number of middle income and developing countries, particularly in South America.[8,9,10] Given the large differences between countries, social health insurance systems cannot simply be imported from abroad but must be individually designed for each country.

Before discussing National Health Insurance, it is helpful to briefly examine the concept of insurance. The basis of insurance is the sharing of risk. For any individual the chance of significant ill health or injury at any one time is low but cost of treatment of illness or injury can be prohibitively expensive. What we in South Africa call medical aid is, in many countries, considered a form of private health insurance which reimburses the cost of treatment should one fall ill.[11]

In a typical private health insurance system, membership is voluntary for individuals but may be compulsory for employees in employment related schemes. Contributions are usually independent of level of income. Individuals who are ill or at higher risk of illness are charged higher premiums (risk rating). A wide variety of packages of benefits may be offered. Recent legislative changes which abolished minimum benefits and have allowed risk rating[4,6,12,13] make our medical aids more typical of private insurance systems.

One of the most common forms of financing health care worldwide.

National Health Insurance is a system of financing health care in which countries use the insurance principle to cover large groups of people, especially everyone employed in the formal sector. The main features of NHI are described in the following paragraphs and typical differences between it and private insurance are summarised in Figure 1.

Compulsory

Must be individually designed for each country.

Membership is usually required by law for all those working in the formal sector. This is so that risks are pooled over large populations. Healthier individuals subsidise the costs of individuals whose higher health risks would make their premiums unaffordable. This allows a greater proportion of the population to be covered than under an entirely voluntary system.

Figure 1. Differences between typical private and social insurance systems

	Private Insurance	Social Insurance
Membership	Voluntary	Compulsory Informal Sector
Contributions	Not related to income	Related to income
Risk Rating	Commonly used	Not used
Benefits	Vary between schemes	Standard package
Administration	Multiple Schemes	Single or Multiple Schemes
Coverage of SA Population	20% covered in 1991	Potentially 40-50%

Contributions

Contributions usually vary according to income so that those receiving lower incomes pay less. Contributions are often less progressive than income tax (in which higher wage earners pay a higher percentage of their income) and are frequently proportional, for example each employee might contribute 6% of his

income. Contributions are usually deducted from the payroll with both employer and employee contributing.

Benefits

All contributors are entitled to a standard package of benefits which typically include curative services. Given the current support for primary health care by virtually all parties in South Africa, the package of benefits paid for by social insurance would almost certainly cover comprehensive primary level care services. The role of the GP is thus likely to be central to the operation of social insurance in South Africa. GPs would be likely to play a "gatekeeping" role to higher levels of care.

Coverage

Social insurance systems usually start by covering a few of the largest employment sectors (eg government employees, large industries). In a country like Egypt, for example, social insurance only covers about 10% of the population. They then gradually expand to cover the rest of the formal sector and employees' dependants. What might this mean in South Africa? Currently 20,1% of South Africans have medical aid cover.[5,14] However about 40%-50% of adults are employed in the formal sector[15] and are thus potential contributors to a social insurance scheme.

In many countries coverage has further expanded (over years to decades) to include other groups such as those employed in the informal sector and the agricultural sector. In some countries such as western European countries and South Korea, 100% of the population is covered. In South Africa the idea has been raised of combining social insurance contributions with tax revenue to form a single health financing system.[3,16] This would represent an immediate jump to 100% coverage with general tax revenue subsidising those who are unemployed and unable to make contributions. While considerations of equity make these proposals attractive, the extent of cross-subsidisation that they would involve make them far less likely to be acceptable in the current political and economic climate than a social insurance system which covers contributors only.

The basis of insurance is the sharing of risks.

Administration

Who administers the NHI? There are many possible variations, from independent bodies to government bodies (such as Ministry of Health or Labour) to private administrators. In some countries (such as Australia) there is one single large national scheme whereas in others (such as Germany) there are multiple schemes. In South Africa the administrative infrastructure of the medical aid schemes might well be compatible with the multiple scheme approach. Where there are multiple schemes funds may be pooled centrally and distributed to each scheme to compensate for the different risk profiles and contribution levels of their members (as in the case in Germany). Larger schemes permit more risk pooling, cross subsidisation and administrative efficiency.[17]

The role of the GP will be central in social insurance of RSA.

Provision of services and mechanisms of reimbursement

Two main patterns of provision of services are described. In the direct

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pattern of provision the insurance owns facilities such as clinics and hospitals and employs its own staff. In the indirect pattern the insurance contracts with independent practitioners (such as GPs with their own premises) to provide services. Over the last decade there has been a move towards the indirect method of provision.

Practitioners may be paid on a fee for service basis (Australia, Germany), a capitation basis (United Kingdom, Netherlands) or a salary basis (Israel, Sweden) or combinations of these. Mechanisms for reimbursing hospitals include a set fee for each day of stay (per diem), payment according to diagnosis (such as Diagnosis Related Groups) giving hospitals yearly operating budgets (global budgeting) or fee for service.[17] Different mechanisms of payment have been shown to have a substantial impact on patterns of patient care.[17,18]

Legislation

Legislation would be likely to specify a package of benefits which every contributor is entitled to receive (to ensure that essential services are covered) and a schedule of contributions that would vary with income. Charging higher premiums on the basis of risk (risk rating) would not be allowed. Voluntary private insurance for additional benefits (top up insurance) is usually allowed.

Reasons to introduce social health insurance

There are many reasons to introduce a system of social health insurance in South Africa. These include:

1. NHI is a sustainable and effective way to increase financial resources into the health sector.[19,20] The potential for expanding health services through increased government finance is limited in many developing countries.[21] Health insurance contributions are usually more willingly paid than increased taxes. By making contributions compulsory over a large part of the population a significant level of resources can be generated.

2. NHI could increase the proportion of South Africans with access to skilled practitioners currently in the private sector. In South Africa 50%-62% of non-specialist doctors, 60%-66% of specialists, 80%-93% of dentists and 89%-92% of pharmacists practise within the private sector.[5,22,23] GPs would be in a position to treat, on a more regular basis, patients who can at present only infrequently afford "out of pocket" payments for their care.

3. The establishment of a NHI should decrease the load on public facilities so that the public sector can concentrate on the most needy areas, important public health interventions and making primary health care accessible to all.

4. A social health insurance provides for a certain amount of "solidarity" and cross-subsidisation to redress the social inequalities of apartheid.

5. Social insurance provides a feasible way of meeting the demands of organised labour whose members are demanding health insurance cover and better health care. NHI could improve care of a substantial part of the population currently not insured especially workers and their families.

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6. NHI may provide opportunities to direct health expenditure to more efficient forms of care including primary health care.

isks of social nsurance

There are several well recognised potential disadvantages which must be considered and addressed.

1. Social health insurance, if benefits are for contributors only, does not do away with a two-tiered health service. This may be socially divisive.

2. The social insurance system may drain valuable staff away from the public sector, as increased funding creates additional demand for care.

3. Social health insurance systems tend to lead to the growth of hi-tech expensive curative medicine in urban areas, particularly if schemes are poorly controlled.

4. Prevention, primary health care and rural services have been neglected in several countries with social insurance systems.

Conclusions

Medical aid scheme insolvency, escalating costs and premiums, exclusion of elderly and ill persons from schemes, and increasing demands from organised labour for health insurance cover, are likely to lead to pressure on the government for reorganisation of the private health insurance market. Compulsory social insurance is the mechanism most widely used in other countries to response to some of these issues. South Africa's high unemployment rate means that restriction to the formally employed and their families is most feasible in the short term. Social health insurance would pose opportunities and risks to health professionals and the public. However there are opportunities to improve equity and efficiency of health care, with emphasis on primary care provided by GPs.

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