# MAF013 Towards developing sustainable national health insurance in South Africa

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**Abstract**

Recently South Africa embarked on a process to implement a National Health Insurance (NHI). Internationally a number of countries have or are in the process of implementing a national health care system. Several countries that introduced the system are however faced with the reality of an unsustainable system. This paper used an archival research method to identify challenges other countries faced in order to ensure the future sustainability of the South African National Health system. The initial analyses revealed that two themes exist when considering why systems are not sustainable. The first theme was the continuous increase in the cost of providing health care, especially due to increases in life expectancy and aging populations. The second theme focused on the provision of adequate financing to sustain the system, especially in the light of the ever increasing cost.

Internationally three main sources are used to finance national health care systems with each country using a different model depending on the country's fiscal capacity. Several countries finance all or most of their health care cost through allocations from tax collections. Countries included in the study made use of different tax collection strategies with some countries making use of targeted sin taxes to support the health care system whilst other merely allocated funds from their general tax collections. The second funding option that is used is 'out-of-pocket payments'. The analysis revealed that there is a fine line between charging too little, which can result in misuse of the system and charging too much with excludes poor people from the system. Some developing countries are dependent on donations to maintain their health care systems (the third financing option). National Treasury has announced that, at least initially, the national health insurance in South Africa will be financed through transfers from the National Revenue Fund to the Department of Health, who is responsible for administering the National Health Insurance. A more sustainable funding model must however be developed to ensure sufficient funds are obtained to maintain the system in the long term.

**Key words:** National Health Insurance (NHI), out-of-pocket payments, national health care system, sustainable health care

## INTRODUCTION AND BACKGROUND

The South African government is in the process of developing and rolling out a National Health Insurance (NHI) with the aim of achieving 'universal coverage' in health care. This project has the potential to improve the lives of the 69.9% of South Africans who are dependent on public health (Statistics South Africa, 2013). Implementing a national health system has internationally proven to be problematic, specifically the development of a

sustainable financing model (de la Rosa & Scheil-Adlung, 2007; World Health Organisation, 2012). The main challenges in designing a sustainable health care system are twofold, namely managing the cost incurred to provide the services as well as obtaining the resources required to fund the system.

This principle is based on the principles contained in the basic accounting equation (E = A – L). The change in the equity, assets and liabilities for a period is the result of the income and expenditure for that period ($E_i = i_i - e_i$). The components considered in this paper are based on this basic equation namely the funding required to maintain the system ($i_i$) and the expenditure to provide the services ($e_i$). As any National Health insurance does not aim to make a profit at the end of the year it is expected that $i_i = e_i$ (or $E_i$ = R0). Based on lessons from other countries this paper considers the different financing options and specific cost considerations.

Even more so than for other social development programs provided by government, the national health insurance scheme is and will be faced with severe cost pressures. Several of these cost increases (also referred to as medical inflation) are as a result of international improvements in health care, for example, technological advances in equipment used to provide medical care (biotech developments), improvements in drugs used to treat life threatening diseases and scarce resources required to provide required medical services. For the system to be financially sustainable the *fiscus* (i.e. National Treasury) must find adequate resources to finance the cost, not only initially, but also in the long term. Internationally both developing and developed countries have and are facing challenges in ensuring the sustainability of their national health care programs.

The research objective of this paper is to consider problems experienced by other countries in developing a financially sound national health care program. A review of historical data was undertaken to identify what actions (successful or unsuccessful) other countries took to provide sustainable funding. It should be noted that the historical background of a country has a significant impact on the challenges and solutions developed by each countries. This research paper firstly provides a theoretical framework for developing a financially sustainable national health insurance. This will be followed by a brief overview of the historical development of the South African health care system and how it has contributed to the current state of health. This is an important aspect of the research as it provides the country context to be considered when developing the systems. In the final part of the paper experience will be draw from countries which are currently operating, introducing or have previously operated a national health care systems. These countries will be analysed to consider problems experienced in their health care systems, how these were addressed and if policy makers can learn any lessons from it. This information can provide the South Africa government with valuable insight in ensuring universal coverage is obtained. According to Tanner (2008) by reviewing and analysing the data and problems experienced in other countries important lessons can be learnt.

## RESEARCH PROBLEM AND METHOD

The research objective of this paper is to consider problems experienced by other countries in developing a financially sustainable national health system. Although cost is an important challenge in all systems, some of these costs are beyond the control of the scheme, for example, new equipment required to treat diseases and the global increase in chronic diseases. Some countries have however identified controllable costs that must be addressed in the development and implementation of a national health care system. The biggest challenge faced in developing a financially suitable health care system is obtaining the required funding. In order to achieve the objective of this paper the following research questions was formulated:

What lessons can be learnt from other countries to ensure that
the South African National Health Insurance is financially sustainable?

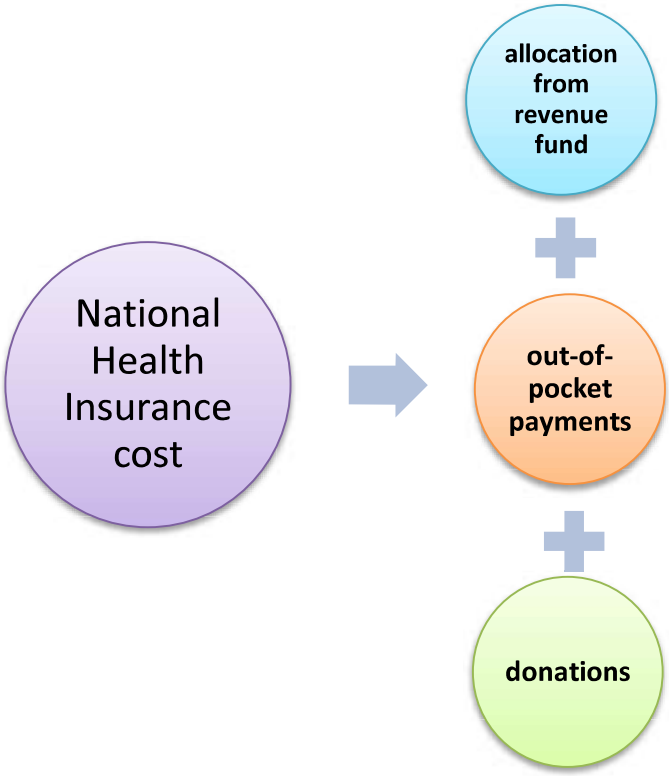
The paper adopted an interpretive research approach as it seeks to understand and describe events (Babbie & Mouton, 2009). An archival research method was used as historical documents, reports and article were examined to identify information relevant to the topics under review. The documents were obtained from library searches conducted with the assistance of a librarian as well as seminal work used by other authors in their documents, reports and articles.

## DEVELOPING A SUSTAINABLE NATIONAL HEALTH CARE SYSTEM

Internationally, the high and rising costs of providing medical services have been identified as risks in establishing a sustainable national health care system (Mossialos, *et al*, 2002). The World Health Organization (2010) recommended that low income countries spend approximately US$60 per capita per annum in order to reach the Health Millennium Development Goals by 2015. It is interesting to note that in 2012 South Africa spent US$645 per capita per annum (World Bank, 2012) which far exceeds the WHO's recommendation yet it is still not achieving universal coverage. This high spending in South Africa indicates that not only are managing costs a problem in the system but also significant funding will be required to develop a sustainable National Health Insurance.

Internationally countries use various sources to obtain the funds required to maintain their national health care systems, each with its own benefits and disadvantages. Goodwin (2008) identifies the following major revenue sources that can be used: allocations from revenue funds (funds collected from direct taxes, indirect taxes, social health insurance premiums), out-of-pocket payments made by users and loans, grants or donations. Each national health care system should find a balance between expenditure incurred and funding received (required). The funding required to sustain the health care system can either be from one source or a combination or mix of different sources (Mills & Bennett, 2002). Figure 1 illustrates how the system should be balanced.

**Figure 1 Balancing a national health care system's finances**




According to figure 1, after determining the costs required by the NHI to provide the health care services, the next step is to determine which source(s) should be used to finance these costs. Internationally the three main funding options used are (World Health Organisation, 2010; Yisa, Fatiregun & Awolade, 2004; Mills & Bennett, 2002; de la Rosa & Scheil-Adlung, 2007; Fineberg & Hunter, 2013):

- *Allocations from revenue fund*: Also known as single payer funds. A portion of the revenue collected by the government, normally through different forms of taxes, is allocated to the health care system.
- *Out-of-pocket payments:* The system is also referred to as user charge system or pay as you go system. Under this system a portion of the cost to provide the services is recovered from the user at the time of usage.
- *Donations:* International organisations like the United Nations support the health care in certain countries by donating either money or medical supplies to the country.

The resources allocated as well as the services obtained may significantly affect health care in a country (Jönsson & Musgrove, 1997). The importance of managing the cost of the system is critical as evidenced by a World Health Organization report in 2010 where it is estimated that globally between 20% and 40% of all health spending worldwide is wasted through inefficiency and the lack of implementation of policies (World Health Organization, 2010).

The World Health Organisation (2010) reiterates that when developing a sustainable health care system it is critical to understand the context within which the system must operate. Two aspects should be considered namely the current services being provided and the funding options available. The next section provides a brief overview of the history of health care in South Africa and its impact on the current state of health.

## THE HISTORY OF THE SOUTH AFRICAN HEALTH CARE

The World Health Organization states that health care is a basic human right that a just society (through its government) is obligated to provide, as far as possible, to all its citizens (World Health Organization, 2010). The South African history is permeated with discrimination based on race and gender (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Prior to the 1994 democratic elections, South Africa's health system was biased and fragmented (Coovadia, *et al* 2009; Van Rensburg and Benatar, 1998; Phatlane, 2006).

Even before democratisation various committees (the 1994 Healthcare Finance Committee, the 1995 Committee of Inquiry and the 2002 Taylor Committee) recommended the establishment of a national health system (Dhai, 2011; McIntyre, Baba, & Makan, 1998). Following the recommendations in 2002 by the Taylor Committee the National Health Act was passed in 2004 which provided a framework for a single health system for all of South Africa. More than a decade later this has not yet been realised. However, the proposed implementation of a National Health Insurance started the process of assessment to address the current situation, as well as the challenges in the South African health system.

Despite the fact that South Africa spent 8.8% of its GDP on health care in 2012, it performed poorly if measured against the health millennium goals of the World Health Organisation (WHO Report, 2010; Vega, 2013). The reason for this can partly be found in the fact that 4.1% of GDP is spent in the private sector and 4.2% in the public sector. The 4.1% spent in the private sector caters for the needs of 8.2 million people which accounts for 16.2% of the population. The other 4.2% of the budget caters for the needs of 42 million people which accounts for 84% of the population. (World Bank Statistics, 2012).

To improve the services provided in the public health care system in the long term, it is imperative that the national health insurance being implemented is sustainable. A pre-requisite for a sustainable system is that it should be adequately funded to provide and maintain the health care services provided, and this brings us back to the purpose of this study the Minister of Finance announced that the system will be funded through transfers from government until alternatives have been investigated (National Treasury, 2013).

Although National Treasury is responsible for managing the government's income and expenditure, the specific expenditure incurred is managed by a specific department, in this case the Department of Health.

As part of the process of implementation, Government has announced that the National Health Insurance would be introduced over a 14-year period and will require the following funding:

| | |
|---|---|
| 2012 | R125 billion |
| 2020 | R214 billion |
| 2025 | R255 billion |

(National Treasury, 2013)

From the brief overview it is clear that the South African health system faces many challenges in providing adequate service to all its residents in order to meet its objects of universal coverage. In South Africa the funding required to sustain the health system poses various challenges including wide-spread poverty that limits the use of out-of-pocket payments as a source of funding and this in turn leads to a decline in revenue collected by government. The next section analyses the problems experienced in implementing a national health care system (either national health insurance of similar scheme).

## RECOMMENDATION WHEN IMPLEMENTING A NATIONAL HEALTH CARE SYSTEM

### Introduction

This section considers the findings by studies investigating the implementation of national health care systems in other countries. There are inevitable comparability concerns when comparing the experience in other countries even when considering a similar group of countries. What is culturally acceptable in one country may not be acceptable in another country. The population distribution, employment patterns, perceived corruption in the system and the levels of literacy all contribute to the success of a system. For all these reasons, the financing and management of a health care system may work well in one society may not work well in another (Abel-Smith, 1985). Yet despite these limitations, valuable insights can be obtained when analysing successes and failure of other countries that have implemented a new system, such as a national health system (Mills & Bennett, 2002).

At the turn of the millennium several low and middle income countries considered implementing a health care system or needed to sustain or improve their existing systems, e.g. China (Bloom & Xingyuan, 1997), Thailand (Tangcharoensathien, Supachutikul, & Lertiendumrong, 1999; Nitayarumphong & Pannarunothai, 1998; Khoman, 1997), Vietnam (Ensor, 1999), Indonesia, Philippines, Bangladesh (Harpham & Tanner 1995), Kazakstan (Ensor, 1999), Russia (Sheiman, 1995), Bosnia, Romania (The InterHealth Institute, 1998), Hungary (Donaldson & Gerad, 1993; Deppe & Oreskovic, 1996) and the Czech Republic (Deppe & Oreskovic, 1996). Some countries are still in the process of implementing their systems or deciding to postpone the implementation of their systems. The results presented in this section are limited to those countries, including high income countries, which have implemented a national health insurance or similar system and for which research results have been published.

For each of the countries a short overview of some of the important features of the system are provided followed by the aspects South Africa should consider when implementing their National Health Insurance. It should be noted that due to the limited scope of the paper, the overview provided does not aim to provide a comprehensive discussion of all the features of the system under review.

**South Korea**

Already in the 1960's the Republic of Korea began building infrastructure to support health care (Mathauer, Xu, Carrin & Evans, 2009). Since 1989 universal coverage was at the heart of the political agenda and in 2010 this was achieved (universal coverage in excess of 98.5%; Jeong, 2010). One of the key events that lead to this achievement was the 2000 change in legislation that integrated more than 300 individual insurers into a single national fund (Kwon, 2003). This change resulted in a more equitable distribution of resources and a reduction in the out-of-pocket payments (Kumar, 2011). The current system uses compulsory wage-based contributions, medical aid schemes and out-of-pocket payments.

*Lessons from South Korea*

- The single fund provided strong economies of scale that reduced the cost of health care in the country (McIntyre, 2011).
- The out-of-pocket payments hampered patients from seeking certain medical treatment which in the long term led to an increase in the number of people with chronic diseases or requiring hospitalisation (Kumar, 2011).
- To reduce the high cost of hospital care for chronic diseases (for example HIV/AIDS and TB) a well-developed community-based chronic disease management programme should be introduced at primary care facilities (Blecher, Kollipara, DeJager, & Zulu 2011).

**Thailand**

Thailand's socio-economic conditions are dominated by an informal economy (World Health Organization, 2007). Initially Thailand had numerous health schemes with inefficiencies prominent in all of these schemes (De la Rosa & Scheil-Adlung, 2007). In 2002 a universal coverage scheme known as the "30 bhat scheme" was introduced. In terms of the scheme a person only had to pay 30 bhat (approximately $0.70 US in 2002) per medical visit or hospital admission, as the cost of health care was mainly financed through a combination of payroll, general and sin taxes. The effect of this scheme was that coverage increased to 95% of the population (Chanwongpaisarn, 2010).

*Lessons from Thailand*

- Sustainability should be planned for by identifying and earmarking additional sources of funding such as an additional or a portion of a specific sin tax. These taxes should be aimed at products that increase the future cost of health care for example tobacco (Tangcharoensathien, 2011).

- Good governance forms the corner stone of success, including decision-making mechanisms, developing capacity building and communication policies that are geared towards the patient (Tangcharoensathien, 2011).

**Ghana**

After independence in 1957 Ghana's health care system was a no fee system as it was mainly financed through external donor support and general taxation revenue (Eghan, 2011). Since the 1980's fees to cover part of the costs of government facilities were introduced. This saw a simultaneous increase in the number of private health care providers (McIntyre, *et al*, 2008). The high out-of-pocket cost and lower heath care coverage lead to the introduction of the National Health Insurance System in 2003, with the aim of providing basic health care services to residents (De La Rosa & Scheil-Adlung, 2007). The National Health Insurance Scheme was funded through premiums and registration fees which were supplemented by a 2.5% mandatory contribution from formal sector worker pension's contributions and 2.5% health insurance levy (Eghan, 2011).

*Lessons from Ghana*

- Collaboration with international agencies and donors is essential to ensure technical and financial assistance is obtained to service poor communities (De La Rosa & Scheil-Adlung, 2007).
- Mixed financing mechanism must be used to obtain a health system that provides universal coverage, but is still affordable. Out-of-pocket payments reduce the unnecessary use of medical services (De La Rosa & Scheil-Adlung, 2007).
- The successful implementation of a health care system requires proper enforcement of legislation (both in terms of levies imposed as well as out-of-pocket cost).
- One of the major challenges identified by Ghana's authorities is the lack of adequate information technology capacity. Due to an increase in the volume of claims and a weak communication strategy to update stakeholders and suppliers several problems were experienced. Current improvements to the system include the rollout of regional offices to provide administrative services (Eghan, 2011).
- During the implementation of the system, investment must be made in good governance, public awareness campaigns and strengthening the capacities required in the system (Eghan, 2011).

**Germany**

Since the first introduction of Social Health Insurance in Germany in 1883 it took more than 100 years to reach its objective of universal coverage (Barnighausen & Sauerborn, 2002; Rompel, 2011). The German health system was founded on the principles of free choice of providers (patients have the freedom to choose to be a member of the publicly administered Social Health Insurance or a private health insurance). The German system offers more than 100 insurance options but all with largely unified compensation system for the providers.

Membership options and payment are based on the individuals need, with elements being subsidised to ensure access by the poor (Reid, 2011).

*Lessons from Germany*

- Every country needs a clear vision of its objectives which in turn needs to be communicated to all stakeholders and supported by legislation to ensure that human rights and patient safety are protected (Reid, 2011).
- Emphasis should be placed on efficiency to ensure value for money and in generating resources to sustain the system (Rompel, 2011). In Germany adequate and almost equal access to benefits was achieved within a diverse environment with measures to ensure effective cost containment.
- Different options can exist in one health care system. Although additional benefits exist in private medical funds more that 87% of the population belong to the public Social Health Insurance (Reid, 2011).

**Australia**

Australia has for several decades had a mix of public and private health care. In the early 1970's, 80% of the population belonged to a private health insurance (Sayer, Miller, Charles, Scahill, Horn, Bhasale, & McGeechan, 1999). This changed since 1975 when a universal tax-financed health insurance was introduced (Maynard & Dixon, 2002). Under the public system everybody has free access to medical care in public hospitals (with some out-of-pocket costs charged for some services). It should be noted that private health insurance does not discriminate based on health status and can provide lifetime health coverage if taken up early (Mooney, 2011).

*Lessons from Australia*

- Inequalities in access to health services can mainly be attributed to high transport costs and long distances to travel for health care services (Pulver, 2010).
- A lack of accountability in the Australian system results in shifting blame for problems. Therefore accountability should be enforced by governmental laws to ensure success (Mooney, 2011).
- Policy makers and those charged with implementation need to monitor demand led services as these resources tend to be abused if not linked to a cost. However, patient payments need to be kept as low as possible as unaffordable patient payments have shown to undermine the objectives of universal coverage (Mooney, 2011).

Duckett and Jackson (2000) point out that caution must be applied when considering the Australian model as their policies and intervention's to achieve universal coverage are more radical and comprehensive than other countries and could result in the South African government subsidizing more high income earners.

**United States of America**

Despite having the highest spend on health care (both overall and per capita) the US is the worst performing industrialized country when measuring health care using indices such as infant mortality, life expectancy, and access to health care (Barr, 2011).

In the 1930's and the 1950's a national health care plan was not introduced as it was considered to be too far reaching and expensive. In the 1960's and 1970's the health care system was extended to provide health care for the elderly and the poor (Barr, 2011). As health care costs continued to rise, more and more people were being left without health insurance. In 2010 the Affordable Care Act and a companion reconciliation bill (so called 'Obama care') was passed which promised affordable health insurance to more than 30 million Americans (Westmoreland, 2011).

*Lessons from the United States of America*

- The US system has very high voluntary prepayments and is challenged with significant levels of fragmentation limiting access for all. Cost must be controlled as far as possible (McIntyre, 2011).
- Some form of mandatory prepayment (probably in the form of a tax) is essential to ensure sustainability of affordable health care (McIntyre, 2011).

## CONCLUSION

When introducing a national health system no country starts afresh. All countries have some form of system in place which was developed within the country's historical constraints and opportunities. Building on existing services a national health care plan can be developed to achieve universal coverage, but several countries have shown that achieving this objective is a difficult and long process. When developing a national health care system (like South Africa's National Health Insurance) it is imperative to plan for sustainability. The analysis of other countries' health care systems identified two core components that must be considered. The first being the cost incurred in providing the health care which must be adequately managed. The second aspect that needs to be considered is the funding model that will be used as government, and effectively the taxpayers of a country, will have to fund shortfalls in the system.

The sustainability of health care is problematic due to the expenditure pressures many countries face. The first factor contributing to this is the global nature of health care products and services. Improvements in health care have resulted in increases in life expectancies, which in turn result in increases in chronic diseases associated with age. Some countries' experiences indicate that accountability is a key requirement for an effective system. The results also suggest that economies of scale can reduce the cost of providing health care, provided that adequate infrastructure exists and is managed appropriately. When developing

the fiscal policy dealing with health care sufficient funds should be allocated to develop the necessary infrastructure and the management systems as required by the **Public Finance Management Act 2012**.

The fiscal policy should provide for a sustainable funding model which is critical to the success of any health care system. The consensus amongst authors is that a mixed funding model should be used to ensure that the system provides universal coverage at an affordable price. Out-of-pocket payment should be used to prevent the misuse of the benefits that are provided. It is however important to note that experience from other countries found that high out-of-pocket payment could result in certain people, especially the poorer section of the population, being excluded from the health care system.

Several countries mainly finance their health care system through transfers from government (through their annual budget). The funds so transferred are either from general tax collected or by identifying a specific tax, for example, a sin tax, that can be used to maintain and improve the system, or a combination of the two. National Treasury indicated that initially the funding required to implement the system will be provided from general tax collection. Considering the projected cost of the National Health Insurance fiscal policy will have to be adapted to find additional tax revenue or the effectiveness of the system will have to be improved to reduce the cost.

## BIBLIOGRAPHY


Barbie, E. and Mouton, J. 2009. *The practice of social research*. Cape Town: Oxford University Press South Africa.

Bärnighausen, T. and Sauerborn, R. 2002. One hundred and eighteen years of the German health insurance system: are there any lessons for middle-and low-income countries? *Social Science & Medicine,* 54(10): 1559-1587.

Barr, D.A. 2011. *Introduction to US health policy: the organization, financing and delivery of health care in America*. JHU Press.

Blecher, M., Kollipara, A., DeJager, P., & Zulu, N. (2011). Health financing. *South African Health Review*, 29-48.

Bloom, G., & Xingyuan, G. (1997). Health sector reform: lessons from China. *Social Science & Medicine*, *45*(3), 351-360.

Chanwongpaisarn, L. 2010. *Essays in public health insurance in life-cycle economies*. Boston University.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. and McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, 374(9692): 817-834.

De la Rosa, J. and Scheil-Adlung, X. 2007. *Enabling transition to formalization through providing access to health care: the examples of Thailand and Ghana*. Geneva: International Labour Organisation (ILO) Social Security Department.

Deppe, H. and Oreskovic, S. 1996. Back to Europe: back to Bismarck? *International journal of health services,* 26 (4): 776-802.

Dhai, A. 2011. Healthcare reform in South Africa: A step in the direction of social justice. *South African Journal Of Bioethics And Law, 4*(2), 48. doi:10.7196/sajbl.181

Donaldson, C. and Gerard, K. 1993. Economics of Health Care Financing: The Visible Hand. New York: St.

Duckett, S.J. and Jackson, T.J. 2000. The new health insurance rebate: an inefficient way of assisting public hospitals. *The Medical Journal of Australia*, 172 (9): 439-442.

Eghan, K.E. 2011. *National Health Insurance conference: "Lessons for South Africa".* National Consultative Health Forum. Department of Health, Republic of South Africa, pp 21.

Ensor, L. 2013. SA 'achieving more positive health outcomes'. *Business Day*. Available at: http://www.bdlive.co.za (accessed on 20 June 2014).

Fineberg, H.V. and Hunter, D.J. 2013. A global view of health—an unfolding series. *New England Journal of Medicine,* 368(1): 78-79.

Goodwin, N. 2008. *National health systems: overview*. London, UK: Elsevier Inc.

Harpham, T., & Tanner, M. (Eds.). (1995). *Urban Health in Developing Countries: Progress and Prospects*. Earthscan.

Jackson Pulver, L. R., Haswell, M. R., Ring, I., Waldon, J., Clark, W., Whetung, V., & Sadana, R. (2010). Indigenous health: Australia, Canada, Aotearoa, New Zealand and the United States: laying claim to a future that embraces health for us all. *World health report*.Jönsson, B. and Musgrove, P. 1997. Government financing of health care. *Innovations in Health Care Financing*: 41-65.

Khoman, S. 1997. Rural health care financing in Thailand. *World Bank Discussion Papers*: 183-194.

Kumar, A. 2011. *National Health Insurance conference: "Lessons for South Africa".* National Consultative Health Forum. Department of Health, Republic of South Africa, pp 16.

Kwon, S. 2003. Healthcare financing reform and the new single payer system in the Republic of Korea: social solidarity or efficiency? *International Social Security Review*, 56(1), 75-94.

Mathauer Inke, X. K, Carrin, G. and Evans, D. 2009. *An analysis of the health financing system of the Republic of Korea and options to strengthen health financing performance*. Geneva: World Health Organization.

Maynard, A. and Dixon, A. 2002. Private health insurance and medical savings accounts: theory and experience. In: *Funding health care: options for Europe*, 109-127.

McIntyre, D., Garshong, B., Mtei, G., Meheus, F., Thiede, M., Akazili, J., & Goudge, J. (2008). Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*, *86*(11), 871-876.

McIntyre, D., Baba, L. and Makan, B. n.d. Eq*uity in Public Sector Health Care Financing and Expenditure in South Africa: An Analysis of Trends between 1995/96 to 2000/01*. Technical Report to Chapter 4 of the 1998 South African Health Review. Health Systems Trust: Cape Town.

Mcintyre, D.I. 2011. *National Health Insurance Conference: Lessons for South Africa*. National Consultative Health Forum, Department of Health, Republic of South Africa.

Mills, A. and Bennet, S. 2002. Lessons on the sustainability of health care funding from low and middle-income countries. In: Mossialos E, Dixon, A., Fuguras, J. and Kutzin, J. (eds). *Funding health care: options for Europe*. Milton Keynes: Open University Press, pp. 206-225.

Mooney, G. 2011. *National Health Insurance conference; "Lessons for South Africa".*

Mossialos, E., Dixon, A., Figueras, J. and Kutzin, J. 2002. *Funding health care: options for Europe*. European Observatory on Health Care Systems. Buckingham, Philadelphia: Open University Press.

National Treasury. 2013. Budget Review. Pretoria.

Nitayarumphong, S. and Pannarunothai, S. 1998. Achieving universal coverage of health care through health insurance: the Thai situation. *Achieving universal coverage of health care.* Nontaburi: Ministry of Public Health: 257-280.

Phatlane, S.N. 2006. *Poverty, health and disease in the era of high apartheid: South Africa, 1948-1976*. Phd of Literature and Philosophy. Pretoria. University of South Africa.

Reid, S. 2011. *National Health Insurance conference:"Lessons for South Africa"*. National Consultative Health Forum. Department of Health, Republic of South Africa, pp 25.

Rompel, M. 2011. *National Health Insurance conference: "Lessons for South Africa".* National Consultative Health Forum. Department of Health , Republic of South Africa, pp 25.

Sayer, G., Miller, G., Charles, J., Scahill, S., Horn, F., Bhasale, A., & McGeechan, K. (1999). *Bettering the evaluation and care of health: general practice activity in Australia 1998-99*. Australian Institute of Health and Welfare.

Statistics South Africa (StatsSA). 2013. *Mid-year population estimates*. Pretoria: Statistics South Africa.

Tangcharoensathien, V., Supachutikul, A. and Lertiendumrong, J. 1999. The social security scheme in Thailand: what lessons can be drawn? *Social science and medicine,* 48: 913-923.

Tanner, M. 2008. *The grass is not always greener: a look at national health care systems around the world.* CATO Institute.

Van Rensburg, H.C.J. and Benatar, S.R. 1998. 'The legacy of apartheid in health and health care', in Cockerham, W.C. et al. (eds), *Readings in Medical Sociology*. New Jersey: Prentice Hall.

Vega, J. (2013). Universal health coverage: the post-2015 development agenda. *The Lancet*, *381*(9862), 179-180.

Westmoreland, T.M. 2011. *National Health Insurance conference: "Lessons for South Africa".* National Consultative Health Forum. Department of Health, Republic of South Africa, pp 28.

World Bank. 1993. *World Development Report 1993: Investing in health. Washington:* Oxford University Press.

World Bank. 2012. *World Development Indicators 2012*. Washington, DC: World Bank. Available at: https://openknowledge.worldbank.org/handle/10986/6014 (accessed on 23 March 2013).

World Health Organisation. 2012. *National health accounts statistics*. Available at: http://www.int/nha/country/annex (accessed November 2012).

World Health Organization. 2007. *World Health Statistics 2007*. Available at: www.who.int/whosis/shostat2007_6healthsystems_nha.pdf (accessed 20 September 2013).

World Health Organization. 2010. *Constraints on scaling up the health Millennium Development Goals: costing and financial analysis gap analysis.* Geneva: World Health Organization (Background document for the Taskforce on Innovative International Financing for Health Systems). Available at: http://www.internationalhealthpartnership.net//CMS_files/documents/workinggroup_1_

technical_background_report_(world_health_organization)_EN.pdf (accessed on 16 May 2012).

Yisa, I. O., Fatiregun, A. A., & Awolade, V. (2004). User charges in health care: A review of the concept, goals and implications to national health systems.*Annals of Ibadan Postgraduate Medicine*, *1*(2), 49-54.