WOULD SOCIAL HEALTH INSURANCE IMPROVE SOUTH AFRICAN HEALTH CARE? WHAT OTHER MIDDLE INCOME COUNTRIES CAN TEACH US

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Introduction

Government finance for health care is unlikely to increase markedly in South Africa in the near future, despite major deficiencies in basic services. While the state's ability to raise taxes is constrained, there are competing demands from other neglected social sectors such as education and housing. Health care expenditure is however already substantial, accounting for about 6% of Gross Domestic Product, half being financed through private health insurance (McIntyre, 1993). Social health insurance, usually referred to as National Health Insurance (NHI), has been advocated as a mechanism for expanding public control of health resources and/or for raising additional revenue for health care, depending on the perspectives of the advocates (Broomberg and De Beer, 1990; Slabber, 1992; African National Congress, 1992; Picard, 1993).

The World Bank has promoted social health insurance for middle-income developing countries internationally. The 1993 World Development Report's main rationale for promoting health insurance is that by providing a payment mechanism for financing 'discretionary' care for those who can afford it, NHI allows governments to focus expenditure on ensuring universal access to 'essential' health care - interventions which have the greatest impact on death and disability (World Bank, 1993:119-123). The Report also argues that by requiring all health insurance cover to include a basic package of essential services, governments can target their expenditure on the uninsured poor. Other justifications are that NHI can increase financial resources for public health care better than can general taxation, because people are more willing to pay insurance contributions in return for a tangible benefit, and because a health insurance fund cannot easily be appropriated by governments to finance non-health expenditures.

NHI is but one of many potential sources of health care financing, but is the major source in many high- and middle-income countries. It is usually based on compulsory contributions by employers and employees in the form of a payroll

tax. Individuals unable to afford compulsory insurance would usually be excluded from benefits, but could potentially be subsidised by the premiums of wealthier workers and/or by government contributions. NHI may be conceived narrowly as a financing mechanism, or more broadly as an integral part of a national health care programme. While the feasibility of NHI financing in South Africa needs detailed investigation, of equal concern is the potential impact of NHI on the nature and distribution of health care provision.

South Africa has poorer health indicators than other countries with similar per capita incomes (Table I). A large proportion of the population has poor access to basic effective services. Distribution of health care is grossly unequal, whether one compares geographical areas, racial categories, or public and private sectors. Doctors appear to be the most unequally distributed resource. Doctor:population ratios are 11 times higher, and bed:population ratios 1.9 times higher, in the country as a whole than in 'homelands', (Naylor, 1988), and doctor:population ratios are 6.8 times higher in the private than in the public sector (Rispel and Behr, 1992). Health care expenditure per capita in 1987 was 4.3 times higher for whites, and 2.5 times higher for Asians, than for Africans (McIntyre and Dorrington, 1990). Although less than 20% of the population has private insurance coverage, 59% of doctors are in the private sector, while public services for the uninsured 80% employ only 41% of doctors (Rispel and Behr, 1992). Under a democratic government, popular pressure for greater equity in health care is likely to increase.

Fee-for-service payment for private health care - in which doctors, hospitals and others are paid proportionally to the quantity of services they provide - has impaired efficiency by encouraging excessive medication, surgery, hospitalisation, and doctor consultations in South Africa (Broomberg and Price, 1990a, 1990b; Price and Broomberg, 1990). Costs to private insurance of medication and hospitalisation increased by 36% and 49%, respectively, between 1989 and 1990 (McIntyre, 1990), reflecting increasingly technical care. The public health service is also excessively hospital-oriented, with about 30% of the total health budget devoted to 13 teaching hospitals (McIntyre, 1993).

As this paper will show, there are many options within a social health insurance programme, with corresponding policy implications. It will be argued that a well managed public programme in South Africa could improve the efficiency of health care by, for example, promoting primary health care, and could improve equity by extending better health care to a greater proportion of the population. However, as universal insurance coverage is improbable given high unemployment rates, NHI would probably have to begin with people in formal employment and their families, with the state continuing to provide services directly to the rest of the population. Thus publicly managed NHI is likely to involve the new

government in formalising inequality between the insured and uninsured, institutionalising the social divide between the employed and unemployed. The government faces a dilemma: either to allow the private health sector to continue to lavish health resources on the minority that can afford them (possibly adding some regulations), or to take control of the finances and accept responsibility for what will probably be a two-tier national health system. The central policy issue is control of health care through control of finance. In any case, protracted negotiations with employers, unions, and health professionals will be necessary to accommodate conflicting interests. It is thus unsurprising that the African National Congress's National Health Plan for South Africa (African National Congress, 1994) has deferred a decision on this question, proposing only that a commission of enquiry be established after elections, following a strategy similar to the Clinton administration's national health plan in the United States.

This paper will draw heavily on the experience of middle-income countries of Asia and Latin America. These countries are more economically and socially comparable to South Africa than are developed nations, or the poorer countries of sub-Saharan Africa. The former countries have similar per capita incomes to South Africa, indicating that similar levels of health care are affordable (Table I). They also have similarly unequal income distributions, making equity considerations important. Many Latin American countries have more than 50 years of experience of social health insurance, and some Asian countries have, more recently, attained near-universal insurance coverage.

Insurance coverage

The proportion of the population insured (coverage) is crucial to the effects of insurance on equity (World Bank, 1993:121). Less than 20% of South Africans have private health insurance, the rest depending largely on public services, or out-of-pocket payments for private services (McIntyre and Chetty, 1992). Where employees are insured through their work, their dependents tend not to be insured, especially among lower earners. Coverage is low compared to countries of similar income (Table I). Could NHI significantly increase this proportion?

Coverage has increased steadily in most Latin American countries, starting in the 1930's and accelerating in the last two decades (Table I). Virtually the whole populations of Brazil (Roemer, 1991), Costa Rica (Roemer, 1991) and (South) Korea (Yang, 1991) are, at least nominally, entitled to insurance-funded care. In Brazil universal entitlement was simply decreed by government during the late-1980s, although a large proportion of the population did not contribute (Roemer, 1991). In most countries, compulsory insurance began with urban workers employed by large enterprises in a few economic sectors, and was gradually extended to other sectors and smaller enterprises.

TABLE I
ECONOMIC, DEMOGRAPHIC AND HEALTH INDICES (1991), AND HEALTH INSURANCE COVERAGE (BETWEEN 1985 AND 1990), IN SELECTED COUNTRIES

COUNTRY	GNP PER CAPITA (US $)	POP. (MILLION)	% POP. URBAN	LIFE EXPECT. YEARS	INFANT MORTALITY RATE (PER 1 000)	HEALTH INS. COVER (% POP.)
LOW INCOME						
CHINA	370	1150	60	69	38	40
ALL LOW INCOME	350	3127	39	62	71	
LOWER-MIDDLE INCOME						
BOLIVIA	650	7	52	59	83	30
PHILIPPINES	730	63	43	65	41	37
PERU	1070	22	70	64	53	19
THAILAND	1570	57	23	69	27	39
TURKEY	1780	57	63	67	58	35
COSTA RICA	1850	3	48	76	14	100
CHILE	2160	13	86	72	17	13
ALL LOWER-MIDDLE INCOME	1590	774	54	68	42	
UPPER-MIDDLE INCOME						
S. AFRICA	2560	39	60	63	54	20
VENEZUELA	2730	20	85	70	34	50
ARGENTINA	2790	33	87	71	25	75
URUGUAY	2790	3	86	73	21	67
BRAZIL	2940	151	76	66	58	100
MEXICO	3030	83	73	70	36	60
S. KOREA	6330	43	73	70	16	100
ALL UPPER-MIDDLE INCOME	3510	627	73	69	34	
ALL HIGH INCOME	21050	822	77	77	8	

SOURCES: All data from World Bank (1993), except health insurance data from Roemer (1991) (Argentina, Brazil, China, Costa Rica, Phillipines, Turkey), Kutzin and Bamum (1992) (China, Korea), Grosch (1990) (Bolivia, Costa Rica), Mesa Lago (1989) (Peru, Mexico), McIntyre and Chetty (1992) (South Africa).

Extension of insurance to rural populations has usually been restricted by their inability to afford premiums, or by shortages of rural services. Rural Koreans were initially reluctant to pay insurance contributions, as the lack of rural services made benefits unlikely (Yeon, 1985). In Brazil and Mexico, special funds subsidised by government and social security were established to extend coverage to rural areas (Roemer, 1991; Knight and Mahar, 1979; Leal de Aranjo, 1973). Brazil also financed insurance for farm workers with a tax on certain agricultural products (Mills, 1983). Extension of rural health care has been especially successful in Costa Rica, but this was largely financed through the government, assisted by foreign aid (Roemer, 1991).

Brazil, Korea and Costa Rica were only able to take the last step to universal insurance coverage once the majority of their populations were already insured. As the World Development Report cautions, 'only a few middle income countries that have adequate financial resources, political resolve, and administrative capacity will be able to achieve such universal insurance coverage' (World Bank, 1993:161).

For South Africa the feasibility of increasing coverage depends crucially on the numbers of people in the urban formal economy. With estimates of unemployment among the economically active population exceeding 30% (Cooper et al, 1992), and the precariousness of employment for much of the rest, it is doubtful whether sufficient additional payroll taxes could be raised to cover the majority of the population, without severely decreasing benefits currently enjoyed by the insured few through redistribution. It is also questionable whether a democratic government will have the political power and will to use NHI for bridging inequalities between employed and unemployed. It would probably be most feasible for the government to follow the example of most other countries, concentrating initially on expanding and regulating insurance for workers in formal sector employment, with extension to dependents and workers in less formal employment as economic growth allows.

Equity

In middle-income countries with substantial NHI coverage, numerous factors contribute to the persistence or amelioration of health care inequalities (Table II). Doctors are usually the most unequally distributed resource. In Brazil the numbers of doctors per 10 000 population were 17.5 in the southeast, 6.9 in the northeast, and 6.6 in the north (Roemer, 1991). In Korea the corresponding figures were 7 in urban areas and 1.2 in rural areas (Yang, 1991).

Insured people usually have more and better health care than do the uninsured, and coverage is invariably higher in urban than in rural regions. Poor people living in peri-urban shack settlements are also likely to have very poor access to

TABLE II.
RANGES OF RESOURCE SUPPLY AND HEALTH INSURANCE COVERAGE BETWEEN LEAST SERVED AND BEST SERVED REGIONS IN EACH COUNTRY.

COUNTRY	DOCTORS:10 000 POP. LOW-HIGH	BEDS:1 000 POP. LOW-HIGH	COVERAGE(%) LOW-HIGH
Argentina	8.1 - 47	4.3 - 8.4	6 - 100
Bolivia		0.2 - 0.9	11 - 33
Chile	2.1 - 5	3.2 - 4.8	39 - 95
Costa Rica	1.9 - 12	1.1 - 5.7	54 - 100
Ecuador	4.0 - 14	1.6 - 2.8	3 - 20
Mexico	2.4 - 21	0.4 - 3.3	17 - 100
Panama	4.0 - 11	2.7 - 5.2	11 - 75
Peru	0.3 - 19	0.6 - 3.0	3 - 27
Uruguay	6.5 - 35	1.8 - 3.8	17 - 68
South Africa	0.3* - 10**	4.0# - 7.0**	

SOURCE: McGreevey 1990, [27] except South African data from McIntyre and Chetty [8].

LEGEND: * homeland, ** metropolitan, # non-metropolitan

health care and other services (Harpham et al, 1988). In most countries, the wealthy are most likely to be insured. In Brazil (Isuani, 1985) and Dominican Republic (McGreevey, 1990), for example, coverage increased with increasing income level and job status. Over time, expansion of coverage has proceeded in order of decreasing wealth. Unequal coverage may exist even within households, when workers' dependents are not covered, as in Peru (Suarez-Berenguela, 1988), or pay higher fees, as in China (Kutzin and Barnum, 1992).

Inequalities also exist among the insured. Entitlement to care does not guarantee that care is provided. Local services may not exist. User fees, time and transport costs, and lack of knowledge of the benefits of care may deter utilisation, especially for the rural poor. In Mexico City social security clinics were located far from insured residents of poor suburbs, who preferred to pay to use private practitioners closer to home, demonstrating the inequalities that exist even among insured people living in cities (Ward, 1987). In Brazil, social security spent twice as much per capita in the richer southeast of the country as in the poorer northeast (McGreevey, 1990). Utilisation rates among insured Brazilians were twice as high in the southeast as in the northeast, four times as high in urban as in rural areas, and ten times as high in the urban southeast as in the rural

northeast, reflecting unequal access to services (Roemer, 1991). Insured Koreans' utilisation rates increased with increasing income, especially for hospitals (Yeon, 1985). These examples show that insurance coverage is not in itself sufficient to ensure access to care.

There is a danger that NHI may drain scarce resources, such as finance and professionals, from government health services. In most Latin American countries, social security consumed shares of public health finance that were disproportionate to numbers covered. As coverage increases, government expenditure on the uninsured, and on preventive services, may decline. Roemer claims that government health spending has generally been maintained during expansion of social security (Roemer, 1987). In Costa Rica, expansion of social security was accompanied by a marked increase in the government supply of primary care (World Bank, 1993:70). In Uruguay, by contrast, government expenditure, and the quality of its care, declined as insurance increased (Tollman et al, 1990). Similarly, increased social security spending in Brazil was also accompanied by a decrease in government spending (McGreevey, 1990).

Of particular concern is the tendency of doctors to move from public service into private practice. NHI has typically increased demand and financing for private care. Thus Abel-Smith argues that an ample supply of doctors is a prerequisite for NHI (Abel-Smith, 1991). In Latin America, a profusion of private medical schools has helped increase supply to meet the demand (Roemer, 1991). However, despite relatively high doctor:population ratios there, doctors are still largely unavailable in rural areas. Compulsory community service for medical graduates has succeeded in supplying doctors to areas of greatest need in many countries, and is an important option for South Africa (Roemer, 1991). However, such coercion frequently results in poor quality public work, and unofficial private work (moonlighting) (Roemer, 1991). Improved staffing, management and amenities of rural facilities, as well as higher pay, are also necessary to attract professionals to where they are most needed.

NHI has the potential to redistribute resources and wealth from the richer to the poorer, but it may do the opposite. While premiums are ostensibly shared between employers and workers, it may be impossible to determine who ultimately pays, as employers can shift their costs onto workers (through lower wage increases), or onto consumers (through higher prices), depending on labour and commodity markets (Musgrove, 1985). A key objective of NHI is the subsidisation of poorer and sicker people by the wealthier and healthier, as premiums do not depend on individual health risk, but are usually based on income. Whether NHI does redistribute wealth depends on the distributions of payments and benefits in relation to income. Like most income taxes, NHI contributions are also progressive in Costa Rica, as in France and Germany, but

are regressive in Korea, where a low ceiling on maximum contributions means that higher earners contribute a lower proportion of their income (Yeon, 1985). Picard has proposed that NHI in South Africa be financed from a progressive earmarked income tax (Picard, 1993), but it is doubtful whether people earning more than R70 000 per annum would be prepared to pay more than 10% of their income towards NHI, as he suggests would be necessary, at the same time as their benefits were being reduced.

NHI may also be regressive if government subsidies transfer tax revenue, drawn partly from consumption taxes paid by the poor, to health care for the wealthier. Forms of government subsidy of health insurance include i) employer contributions for government workers, ii) tax-deductible premiums, iii) provision of public sector care to insured patients at below-cost prices, and iv) professional training. All four mechanisms operate in South Africa. In China, government subsidies of health insurance were markedly greater for wealthier urban workers than for the rural poor (Kutzin and Barnum, 1992). Government subsidies may, however, be targeted at the poor, as in Dominican Republic, where subsidies increased with decreasing income of beneficiaries (McGreevey 1990).

The direction of redistribution depends not only on who pays, but also on the ratio of benefits to contributions. Despite the inequalities of Brazilian health care, social health insurance transfers wealth from richer to poorer regions. While the poorer northeast contributed 9% of revenue, it received 17% of expenditure. The wealthier southeast contributed 63% of revenue, but only received 53% of expenditure (Roemer, 1991). The city of Sao Paulo contributed 42% of revenue, but drew 24% of spending (McGreevey, 1990).

Korean health insurance, by contrast, appears to aggravate inequality, for two reasons (Yeon, 1985). Firstly, high co-payments and obligatory 'gifts' to doctors deter the insured poor from using health services, especially hospitals and specialists. Secondly, higher earners have more dependents, many of whom are elderly. Yeon showed that benefit to contribution ratios were 25 - 30% higher for wealthier than for poorer beneficiaries, indicating that the wealthy gained more from health insurance than did the poor.

These examples demonstrate the complex influences of health insurance on equity. If health insurance in South Africa, whether private for-profit, or compulsory NHI, remains confined to a minority of the population and continues to drain financial and professional resources away from the public service, it will aggravate inequality. If, however, NHI markedly expands coverage, and if services to the rural and peri-urban poor are extended, with subsidisation through tax or insurance of the poorer by the wealthier, equality will be enhanced. The former outcome is more likely without significant political support for NHI.

Efficiency

Efficiency of health care refers to health effects achieved in relation to resources used. It has become increasingly apparent that greater expenditures on highly technical, specialised and hospital-based care have not led to commensurate improvements in health. By contrast, marked health improvements have resulted from measures ensuring universal access to essential curative and preventive services through the primary health care approach (World Bank, 1994). While available data does not allow comparison between countries of health benefits per unit of expenditure, the efficiency of various health systems can be indirectly inferred from the prevailing patterns of care.

Health care under NHI in Latin America and Asia has typically been excessively costly, hospital-oriented, specialised, highly technical, and urban based. The greatest inefficiencies do not necessarily arise directly from NHI itself, but rather follow from the 'perverse incentive' of fee-for-service reimbursement of private care providers, which rewards excessive hospitalisation, investigation and treatment. Levels of care are typically poorly defined, with the hospital as the usual first point of contact in countries such as Brazil (McGreevey, 1982) and Korea (Kutzin and Barnum, 1992; Yeon, 1985). In Brazil, the proportion of the social security budget directed to hospitals increased from 40% in the 1960s to 50% in the 1980's (Kutzin and Barnum, 1992). Brazilians receiving private outpatient care are eight times as likely to be admitted to hospital as are those attending public facilities (Roemer, 1991). In Brazil, the proportion of hospital inpatients receiving X rays and laboratory tests increased by two to three times from 1970 to 1981 (McGreevey, 1982). Korea has a surplus of highly expensive equipment of doubtful value: for a population of 43 million, it has 28 hospitals equipped for heart transplants, 26 lithotrypsy machines, and computerised tomography in every hospital with over 200 beds (Yang, 1991). Over-medication is also encouraged, severely so in Korea (Roemer, 1991) and China (Kutzin and Barnum, 1992), where drugs account for 57% and 50% of their respective health insurance budgets.

In the countries examined curative care has been emphasised, frequently at the expense of preventive and promotive care. While social security health spending increased in Brazil between 1978 and 1982, government spending on communicable disease control decreased by 41%, including a drop of 57% for malaria, and 80% for bilharzia (McGreevey, 1982).

Primary care has usually been neglected in NHI-funded systems. In most cases, primary care through NHI comprises payments to urban private practitioners. Fee-for-service remuneration has stimulated over-servicing, as in Korea, where the number of doctor consultations per illness episode rose from three in 1980 to five in 1990 (Yang, 1991). There are, however, important exceptions to this

trend, in which primary care is provided through health centres. Urban polyclinics were developed by social security institutes in a number of Latin American countries, with sufficient scale to efficiently provide a mixture of general and specialist care (Roemer, 1987). Brazil has about 7 000 polyclinics, in addition to the 10 000 (mostly public) health posts and centres (Roemer, 1991). Costa Rica greatly increased the distribution of health centres in rural areas, but this was largely undertaken by the government who delegated all hospital management to social security institutes (World Bank, 1993:70).

The inefficiencies described have led to steeply escalating costs in most of the countries reviewed, to which they have responded by increasing premiums and co-payments, and cutting benefits (Ron et al, 1990; Roemer, 1991; Grosch, 1990). Some have attempted to change methods of paying providers but have at times met resistance. In Korea, for example, doctors successfully resisted limits to excessive remuneration for prescribing drugs, which is a major source of income (Roemer, 1991). Cost control is, however, possible in industrialised countries with near-universal NHI coverage, as has been shown by European countries during the 1980's, but has only been achieved through sustained government and insurance institute intervention in health care (World Bank, 1993:125). Central control of health care funding through NHI could enable redirection of resources to the most efficient forms of care (Broomberg and De Beer, 1990), but engagement of insurance institutes and government in health care organisation is crucial (Kutzin and Barnum, 1992; World Bank, 1993).

Organisation

Forms of public sector control of NHI vary widely. In Korea the health ministry has a minimal role, such as restricting the establishment of new hospitals (Yang, 1991). In Brazil, by contrast, the entire insurance system is based within the health ministry (Roemer, 1991). The degree of real control may, however, be unclear. In Brazil, the social security institute retained much of the staff and structure it had before incorporation into the ministry, and wielded more economic and institutional power than did the rest of the ministry. In none of the countries reviewed has NHI been an integral part of a unified government-provided national health service.

A major choice is whether a NHI institute should provide care itself - the 'direct' method - or whether it should purchase services from private or public providers - the 'indirect' method (Roemer, 1987; Roemer, 1991). The early decades of Latin American NHI were characterised by direct provision, in which salaried professionals served beneficiaries in hospitals and clinics owned by social security institutes (Roemer, 1987). Through the 1970s and 1980s the indirect method has become predominant in Latin American and Asian NHI, although

the direct method is still dominant in India and Turkey (Ron et al, Roemer 1991). Both the World Bank (World Bank 1994, 131) and, in South Africa, the Centre for Health Policy (Picard, 1993) argue that the state would improve efficiency by increasing competition between independent providers for public contracts. The Bank warns, however, that 'managed competition requires a high degree of government administrative capacity to set the rules and monitor provider performance'.

Health maintenance organisations (HMOs), in which pre-payment entitles members to a range of services, are a form of insurance. However, as the providers of care bear the costs of care themselves, they have an incentive not to overtreat. HMOs providing urban primary care have expanded in Brazil and cover half of Uruguay's population (Tollman et al, 1990; Briscoe, 1990). Limitations of HMOs identified elsewhere include exclusion of people at higher risk of illness, incentives to enroll too many people and under-treat them, and their failure in rural areas (Tollman et al, 1990). Managed care can take many forms, however, and some of these problems could be avoided through careful design, including a judicious combination of incentives and regulation.

HMOs have expanded in South Africa, and have been shown to be more efficient than insurance-funded fee-for-service care (Broomberg and Price, 1990b). The Chamber of Mines is currently taking steps to get greater control over the provision of employees' health care, rather than leaving it to private insurers and professionals (Fourie, 1993). There is also scope for greater worker control of HMOs, as shown by the participatory management of the ISCOR medical benefit scheme (Kruger, 1993). The latter scheme however also illustrates the limitations of HMOs: only a quarter of low earners could afford to join the most basic scheme, and most workers opted exclusion of their dependents.

These examples show that NHI in South Africa could be organised in a number of ways. In any case, the state will need to take an active role in organising insurance institutes, and in directing finances to areas of greatest need. It is, however, likely that the first task facing a future health ministry, of integrating the highly-fragmented public health authorities into a unitary service organised at national, regional and district levels, will be so great that it will not have the capacity to simultaneously manage the reorganisation of private care through NHI.

Political influences

Equity and efficiency are most likely where insurers, providers, the state and the public have similar objectives, and where programmes are coordinated. Conflicts of interest are inevitable, however, and are played out through overt or

latent political processes.

Mesa Lago (1989) and Borzutsky (1989) have described how social security in Latin America developed under multi-class alliances of industrialists, the middle class (especially government employees) and the organised working class, and was a focus of intense bargaining. The state used social security to 'co-opt, neutralise and control' pressure groups. Much decision-making occurred outside formal structures through elite networks, including government officials, professionals, hospital owners, and social security administrators. The power of social security institutes and labour ministries was often greater than that of health ministries. The privatisation drives of military regimes changed health care from direct provision of services by social security institutes and public services, to fee-for-service payment to private providers. While the poor have generally been excluded from these processes, more recently popular pressures have prompted the expansion of coverage in countries like Brazil and Korea. These examples show how powerful interest groups can influence the direction of health care under NHI.

In South Africa, the greatest resistance to a redistributive and regulated NHI system is likely to come from the current beneficiaries of private insurance, and from the medical profession which would resent any restrictions of professional autonomy and income. Also, if NHI covers only part of the population, there may be substantial popular opposition. Much will depend on the ways in which trade unions and employer organisations see their constituencies' interests being furthered, and how NHI proposals fit in with other social security developments aimed at income maintenance.

Conclusion

The evidence of countries economically comparable to South Africa shows that NHI can increase funding for health care, but also poses risks. If NHI is used to expand the present system of fee-for-service payment for private care, the already critical inefficiencies and inequities will be aggravated. An additional danger is that government health resources could be drawn into expensive ineffective care for the few. Efficiency can however be increased under NHI by i) directing resources to those services which will have the greatest impact on health, by developing a health system based on primary care, ii) continual evaluation of processes and outcomes of care, and critical assessment and regulation of new technology, and iii) creating financial incentives for providers of care, especially doctors, to practise efficiently. Equity can be increased by i) ensuring that the majority of the population is entitled to, and has access to, adequate care, regardless of their ability to pay for it, and ii) subsidisation by the wealthy of the poor.

To promote health for all, NHI needs to be linked to an integrated national system of health care. Particularly needed are programs to ensure access for the poor in rural and peri-urban areas, including the unemployed and the elderly, as have been attempted in Brazil, Mexico and Costa Rica. NHI has the potential to raise and direct large sums of money equitably and efficiently, but it is not a complete solution. Political and organisational complications may distract the state from focusing on the leading priorities - extending basic services to the poor, and putting the fragmented public health system together again.

ACKNOWLEDGEMENTS

The author is grateful to Jonathan Broomberg, Diane McIntyre and Merrick Zwarenstein for their critical comments on earlier drafts of this paper.

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