HEALTH INSURANCE PROVISIONS IN COMMUNITY MICRO FINANCE: A COMMUNITY CASE STUDY

Thabo oa Rakoloti

Submitted in partial fulfilment of the degree of
Master of Development Studies
University of Natal, Durban

2003

ACKNOWLEDGEMENTS

Special thanks to God Almighty, for being with me throughout my hardships and success.

To my supervisor, Professor Francie Lund, thank you so much for nurturing my career and for the unlimited academic guidance you provided.

Thanks to the National Research Foundation (NRF) and the International Development Research Centre (IDRC), in collaboration with School of Development Studies (SoDS), for their financial support.

A special note of thanks to Professor Derek Wang, for his invaluable support throughout my postgraduate studies.

Many thanks to FinaSol and Financial Services Co-operatives (FSC), for providing information and support for this study.

Many thanks are due to my adopted family, for their emotional and spiritual support throughout this long academic journey.

Finally, to all the people who have made a significant contribution in my entire life and throughout my studies, thank you.

This dissertation is dedicated to all men and women who never had the opportunity of capturing the moments of their children's successes, including my mother.

KGOTSO HA E ATE!!

ABSTRACT

Micro Finance Institutions are being advocated as vehicles to provide poor people with loans to start business enterprises. Micro Health Insurance is offered to insure against the risk of ill-health in the enterprise. An interesting aspect of this initiative is that it is donor driven to service the needs of the poor and the 'unbankable.' However, it was the researcher's considered view that it may not be easy to build a sustainable Micro Health Insurance Scheme for poorer people. The study thus sought to explore the possibility of developing a sustainable Micro Health Insurance Scheme in the context of acute poverty, free health care, the burden of HIV/AIDS and other diseases, the growing informal sector, erratic and unreliable incomes and the nature of risks faced by these prospective clients.

To develop a thorough understanding of the subject matter, extensive reading was carried out. The researcher then designed an interviewer-administered questionnaire. The study had a total of 34 respondents, most of whom where members of a Financial Service Co-operatives, which are community-banking structures that provide a range of financial products for poorer people and those in the informal economy. It is clear from the study that these people are faced with a number of risks. There are several problems that may affect the possibility of building a sustainable health insurance scheme.

The present study does not provide any statistical evidence but explores the theme of using the concept of risk and vulnerability to understand the poverty in which Micro Finance and Micro Health Insurance is located. The study provides an array of policy options that can be explored to provide for the health care needs of poorer people, as well as suggestions for future research.

PREFACE

The work described herein was undertaken in the School of Development Studies, University of Natal, Durban, under the Supervision of Professor Francie Lund, of the School of Development Studies, University of Natal, Durban.

The financial assistance of the National Research Foundation (NRF) and the International Development Research Centre (IDRC) for this research is hereby acknowledged. Opinions expressed, and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF and IDRC.

I hereby declare that this is an authentic record of work and has not in its entirety, nor in part, previously formed the basis for the award of any degree of this or any other university. Wherever use is made of the work of others, it is duly acknowledged in the text.

Signed

11 August 2003

Date

Thabo oa Rakoloti

TABLE OF CONTENTS

CHAPTER 3: THE POOR, RISKS, AND MICRO HEALTH INSURANCE

CHAPTER 4: HEALTH CARE IN SOUTH AFRICA

CHAPTER 1

BACKGROUND TO THE STUDY

1 Introduction

This dissertation attempts to explore the possibility of building a sustainable Micro Health Insurance Scheme in a context of acute poverty, free health care, growth of the informal sector and the burden of HIV/AIDS epidemic and other diseases. The terms Micro Health Insurance (MHI), Community Based Health Insurance Scheme (CBHIS) and Mutual Health Organization (MHO) are loosely used in this dissertation to refer to health insurance focused on the poorer people and provided at community level.

In 2000/2001, the Financial Services Co-operatives, which is a South African Micro Finance Institution (MFI), wanted to establish whether it would be viable to build a health insurance scheme, to add to its portfolio of products. It has branches in the Free State, Eastern Cape, KwaZulu-Natal and Gauteng. Even though there is an emotive appeal for Micro Finance Institutions to offer health insurance products, the question is how insurable are the poor? There is a great concern that Micro Finance Institutions are becoming increasingly unsustainable. Surely, the addition of a new portfolio of a product like Micro Health Insurance, that may be tied to Micro Finance, could also be unsustainable.

The attempts to offer a CBHIS are donor driven and are mainly to extend health care coverage to people outside the formal economy, through the use of community banking structures or Micro - Finance Institutions. Community Based Health Insurance Schemes are emerging because of the problems associated with user fees in financing health care (Bennett *et al.*, 2001: 12). These schemes are intended to address equity problems and to widen the risk pool and the cross subsidy between the healthy and the sick, to minimize the financial risk of

accessing health care (Bennett and Gilson, 2001: 12). Much of their eagerness depends on an enticing "win-win" proposition (Morduch, 2000: 617). According to this proposition, Micro Finance Institutions that follow the principles of good banking will also be those that alleviate the most poverty. However, poverty outreach and financial sustainability are two possibly contradictory goals (Morduch, 1999: 1, Rhyne, 1999:6 and Lund and van der Ruit, 2001). What would it take to build a sustainable Micro Health Insurance Scheme, especially when there is free health care and when poverty is so acute? The study does not pretend to have all the answers to these questions. However, it tries to explore some of the issues that should be taken into consideration when building a sustainable health insurance scheme for poorer people. It suggests a number of progressive policy options for financing the health of poorer people and suggests further research that should be undertaken.

1.1 Structure of the dissertation

In dealing with the above aspects of the research, Chapter 1 provides a brief overview of the study area and poverty in South Africa, focusing more on factors, which may influence and affect the possibility of building up a sustainable Micro Health Insurance Scheme.

Chapter 2 describes how the information was gathered concerning the possibility of building a Micro Health Insurance Scheme for poorer people in Qwaqwa.

Chapter 3 outlines the Social Health Insurance policy development, which, if implemented correctly in South Africa, would or could be a mechanism with which Micro Health Insurance could link. This Chapter also provides a conceptual framework adopted for this study.

Chapter 4 deals more with the link between poverty and health status and the health services that poor South Africans particularly those in Qwaqwa have

access to and the health variables that may affect the setting up of a Micro Health Insurance Scheme in Qwaqwa.

As one component of the overall study, a survey was conducted in Qwaqwa and Chapter 5 presents the results of the survey.

Chapter 6 discusses the main findings of the study and provides policy options and future suggestions for financing the health of the poorer people. The conclusion of the study is also found in Chapter 6.

1.2 Qwaqwa

The site of the study was an area typical of many in which Blacks were placed by the apartheid laws (Appendix 1). Qwaqwa is now part of the Free State province and is located just between the mountains of the Drakensberg and Maluti. Like Venda, Bophutatswana, Ciskei and Transkei, Qwaqwa was a Bantustan intended and designed as an exclusive area for the Basotho nation. Chiefs controlled all the Bantustans and Qwaqwa was under the control of Charles Mopedi. The allocation of land was entirely in the hands of Chief Mopedi, who distributed it amongst his subjects. Within a twenty-year period, the population in Qwaqwa rose at an alarming rate, from 24 000 in 1970 to 470 000 in 1990; almost 99,6 % were blacks and the rest were from other ethnic groups (Free Sate Provincial Government, 1999). Qwaqwa has had little of economic development, except in the capital, Phuthaditjhaba, which is the economic hub, but is not well maintained. There has been a decline in construction and government services since the advent of the new democracy. The people of Qwaqwa are now deriving their livelihoods from the informal business sector, state pensions and employment from professionals such as teachers, nurses and other government employees. Around 88% of people in Qwaqwa are living in poverty, compared to the Free State average of 66% (Free State Provincial Government, 1999: 32). In 1990, only 2.8% of the economically active were employed in agriculture. A survey conducted in 1998 pointed to 27% in full or part-time employment, 4.3% in

casual employment and 16.1% pensioners. (Free State Provincial Government, 1999: 32). However, it is important to locate poverty in Qwaqwa in a broader South African poverty context in order to understand it better.

1.3 Socio-economic profile of South Africa

The socio-economic profiles provide an indication of both social and economic performance of the country. This section will give a brief overview of poverty in South Africa. It will focus on variables, which will influence and affect the likelihood of setting up insurance schemes.

"South Africa is an upper-middle-income country with a per capita income similar to that of Botswana, Brazil, Malaysia or Mauritius. In spite of this relative wealth, the experience of the bulk of the South African households is either one of absolute poverty, or that of continued exposure to becoming poor" (May, 2000: 2). The distribution of income and wealth in South Africa is among the most unequal in the world.

May (2000) contends that although considerable progress has been made over the past five years, since the inception of the democratically elected government, African rural women and children, have unsatisfactory access to clean water, energy, health care (which is the focus of this study) and educational facilities (May 2000:2).

There are different ways of measuring poverty. May (2000) identifies 'objective' and 'subjective' ways of looking at poverty. What May suggests is that income levels, consumption expenditure, life expectancy and housing standards are part of the 'objective' social indicators, while attitudes, perceptions and behaviour falls under the 'subjective' indicators. However, defining poverty has never being easy. Despite the evident large numbers of people living in poverty, the definition of poverty has been the subject of some debate (see, among others, World Bank, 1990: 13, Bernstein, 1992: 15, Rakodi, 1995: 408, Lipton and Ravallion, 1997:

2553 and May, 2000:5). If a person within a household or a community is unable to meet the minimum social standard of living or has a feeling of social exclusion from the community, that in itself might constitute poverty. May (2000) points out that the perceptions of the poor themselves are a good foundation from which an appropriate conceptualization of poverty in South Africa can be derived. People experience poverty differently. Some people are currently moving out of poverty and at the same time some are falling into the poverty trap. The situation is caused by the multifaceted nature of poverty.

Conceptualization of poverty can be made from the South African Participatory Poverty Assessment (SA – PPA) that sees poverty in terms of the following:

Sufficiency: a situation whereby a person does not have enough food to eat and to provide for his/her family; lack of income to take children to school or to buy medicines and also lack of opportunities to increase his/her asset base.

Access: This might mean lack of access to credit facilities that might also improve the asset base of the poor.

Security: A situation whereby a person can be harassed by anyone including police officers, more especially in issues relating to the ownership of land. Residents of Qwaqwa suffer from high levels of poverty. The legacy of apartheid left the country with an absence of credible, comprehensive and reliable data that could have helped policy-makers, planners, engineers, financial advisors and developers to formulate policies that are relevant for overcoming poverty and maldistribution of resources. However, there is now the (PSLSD), South African Participatory Poverty Assessment (SA-PPA), Poverty and Inequality Report (PIR) and other sources that encourage and provides reasons for confidence on the information at our disposal. The present study draws from the sources mentioned above.

1.4 Poverty levels in South Africa

Even though there is concern about the definition of poverty, poverty is usually defined either in absolute or relative terms. In absolute terms, poverty means the inability of individuals to meet their day-to-day standard of consumption. In relative terms, poverty refers to lack of resources from groups and individuals, when compared to other members of the society. Poverty levels in South Africa are shocking. The National Labour and Economic Development Institute (Naledi) (http://www.naledi.org.za/poverty.html) compiled the extent of both absolute and relative poverty in South Africa.

They showed that poverty levels are high in rural areas, especially in former homelands and provinces that were underdeveloped because of the legacy of apartheid. The levels of poverty differ from one province to another, gender status and rural –urban setting. The Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa (2002), known as the 'Taylor Report' points out that the number of South Africans living in poverty is somewhere between 45 and 55 percent. The Taylor Report, which analysed poverty in South Africa, revealed that:

- Forty five percent of the population (18 million people) live on less than $2 a day (a poverty line suggested by the World Bank)
- Twenty five percent of African children are stunted
- Ten percent of Africans are malnourished
- Sixty percent of the poor get no social security transfers

Measured by the Gini Coefficient, which shows that the higher the number (close to 1) the higher the level of income inequality and vice versa, inequality in South Africa is among the highest in the world, or at least of those countries in which such measures can be made. Table 1 shows the comparison of income inequality in selected Middle Income Countries (MIC), according to the size of the Gross National Product (GNP).

Table 1: Comparison of income inequality in selected MIC

Indicator	Malaysia	South Africa	Brazil	Venezuela	Thailand	Poland
GNP per capita US$ 1994	3480	3040	2970	2760	2410	2410
Gini	0.48	0.58	0.63	0.54	0.46	0.27
% Share of income of poorest 20%	4.6	3.8	2.1	3.6	5.6	9.3
% Share of income of poorest 10%	37.9	41.9	51.3	42.7	37.1	22.1

(Source: World Development Report, World Bank, 1996)

From Table 1 it is evident that South Africa's Gini Coefficient is 0.58. According to Naledi, this is skewed, considering that GNP per capita is US$ 3040 (also see May, 2000: 28). This implies that income is shared unequally in South Africa; whites have large incomes compared to blacks and other race groups. On the other hand, Poland has GNP per capita lower than that of South Africa but income is distributed more fairly in Poland. The legacy of apartheid contributed much to the unequal distribution of income in South Africa. Blacks were not allowed to enroll at certain white institutions and they also had limited choices in terms of their career paths. This experience of apartheid has affected the

educational levels of most black people. It is accepted that the more educated individuals are exposed to better economic opportunities. The skewed Gini Coefficient might also be related to business opportunities created for whites that contributed much to their wealth. Gini Coefficients can also be calculated for different groups within a particular country as in Table 2, which shows that there is a high degree of inequality amongst blacks, Coloureds, Indians and whites. The National Labour and Economic Development Institute (Naledi) points out that it is interesting that the overall Gini Coefficient of 0.59 is greater than the Gini coefficients within each of the historical racial classifications. However, it is still highest within blacks. According to Naledi this means that inequalities are more pronounced across these groupings than within each category. Looking at income variation and gender, it can be see that the variation in income across male-headed households is much greater (0.75) than across female-headed households (0.55). Naledi points out that the situation might reflect a uniform level of poverty among female-headed households and high levels of income inequality among male-headed households.

Table 2: Gini Coefficients of different types of South African households.

Type of household	Gini Coefficient
All households	0,59
Race of head of household:	
Black	0,52
Coloured	0,50
Indian	0,44
White	0,49
Gender of head of household:	
Male	0,75
Female	0,55
Type of area:	
Urban	0,57
Non-urban	0,55

Source: CSS (1997). Income and Expenditure Survey 1995.

As can be seen in Table 2, the people most vulnerable to poverty are black women and children and those living in rural areas. This is a serious problem as insurance schemes cannot be sustainable under such high levels of poverty. In the Free State province, the incidence of poverty is higher than that in the Western Cape and Gauteng (HSRC, 2002). If FSC wants to set up sustainable health insurance schemes it could focus on Gauteng province, where it has a branch because of low levels of poverty. However, this is the province in which most of the people belong to medical schemes.

1.5 Unemployment in South Africa

The definition of unemployment is widely contested (see May, 2000). There are two commonly used definitions: a "strict" and an expanded definition. The latter includes discouraged and de-motivated individuals who have stopped searching for jobs. However, I was not rigorous about the definition of unemployment.

Statistics South Africa indicates that, despite population growth, there has been a decline in the number of jobs in South Africa from 5.2 million in 1996 to 4.8 million in 1999
(www.statssa.gov.za/Statistical_releases/Statistical_releasess.htm)

Lack of formal employment and the growth of informal work will create problems for anyone who wants to build a sustainable health insurance scheme for the poor. Informal workers often have irregular earnings because of the nature of their work, which is characterized by high levels unpredictability and irregularity. Even those who are employed on a casual and seasonal basis have to wait for jobs within a specific period (e.g. the harvesting period). The unavailability of jobs within a specific period means a loss of income. A lack of reliable income will affect the financial viability of the scheme, mainly because most people will be unable to contribute regularly to the scheme. van Ginneken (1999), when looking at the how the social security system is failing most of these poorer people, points out that "the irregularity of informal sector employment makes it unreliable as a source of income for social insurance contributions" (van Ginneken, 1999: 11).

Surely it cannot be expected that unemployed people should contribute to health insurance when their risks are so compressed. The market is failing to create jobs for the unemployed, and they have sought work in the informal market that is risky and unorganized. Blacks have been hardest hit by the 'unemployment epidemic'. These are the people that the present study focuses on. The chances of building sustainable health insurance in the era of the unemployment epidemic is now questioned and might not be a reality. The chance of building a sustainable health insurance is further decreased by the free health care policy. Most people have a notion that public health services are available free at the state hospitals and therefore would not be willing to contribute towards the costs of their health care.

1.6 Free health care

Free health care entails the provision of health services freely to a certain exempted section of the population (McCoy and Khosa, 1996). In the era of acute poverty, the idea behind free health care made perfect social sense. Shaw and Griffin (1995) indicated that health care in the southern Africa is financed on the basis of user fees. Therefore, the argument for a free health care policy is that charging user fees for services actually excludes the majority of the poor, who are most in need of health care.

This is one of the problems identified by the African National Congress's National Health Plan (1994). The objective was that if user fees were removed then specific population groups would have access and utilize the Primary Health Care system. These include children under the age of 6, pregnant women, elderly people and disabled people. The advocates of equity such as Gilson *et al.* (1999) saw this move as a way of improving access to health care, thus contributing to equity.

However, Abel-Smith (1986) writes "developing countries currently attempting to provide free services for their whole populations are trying to jump two stages of the European transition-voluntary and compulsory insurance." (Abel-Smith, 1986: 6). He says that these developing countries cannot even provide universal health services by taxation. His main point is that European countries waited until their tax base was strong enough to sustain them and then started to provide health services to the whole population. Even though free health care policy has emotive appeal, the policy might be a challenge to anyone who wants to build a sustainable health insurance for the poor, particularly if it is extended to the wider population. Being an insured would mean that a contribution has to be paid to access some of the services that are deemed to be free. Introducing a health insurance scheme in the presence of a free health care policy might not be feasible. In fact, with the emergence of (HIV/AIDS), people are expecting to get anti-retroviral drugs free of charge and this will burden the public hospital's

budgets and at the same time inhibit the development of any health insurance scheme. This expectation stems from the high incidence of poverty and that poverty causes HIV/AIDS.

1.7 Poverty and HIV/AIDS

HIV is a virus, called the "human immune deficiency virus". It gets into a person's body through contact with infected blood or fluids from another person. Budlender (2000) summarized a number of key points about the relationship between poverty and HIV/AIDS. She described how a combination of poverty, violence, social chaos and other poverty related factors might lead to transmission of HIV infection (Budlender, 2000: 114).

Qwaqwa is a good example of an area where migrant labour and broken families can increase the risk of HIV infection. Illness is a risk that can lead to impoverishment of individuals and household. Therefore HIV/AIDS will affect the general health status of most of these people, leading to lower productivity and high cost of care for the sick. The financial impact of HIV/AIDS will be great on these Community Based Health Insurance Schemes, if not well assessed.

1.8 Conclusion

Given the extent of poverty in South Africa, it is clear that there are people who suffer from both absolute and relative poverty. People who are mostly affected are women and children, those staying in rural areas and blacks. Therefore it may be difficult to eradicate poverty in Qwaqwa, where people are more dependent on the informal business sector and state pensions and where the level of economic development is low. Even though there is an emotive appeal for Micro Finance Institutions to provide Micro Health Insurance to insure against risks of ill-health, it can be seen that paying for health in a state of erratic unemployment and in the presence of free health care, increasing levels of HIV/AIDS, growth of the informal economy and increasing levels of poverty will pose serious challenges. It appears that the a number of the people will continue

to rely on the public health system and that general taxation will continue to be a major source of financing the health of the poorer people. At the same time, there is a need to explore whether they will be able to make any significant contribution towards paying for the cost of care. The poorer people are faced with a number of risks and their risks are concentrated. What are the chances of building a Community Based Health Insurance Scheme, given this situation? This is the question addressed by the present study. The next chapter describes how the information was gathered to elicit whether it may be possible to build a Community Based Health Insurance Scheme in a context of free health care, high unemployment, the emergence of chronic diseases, irregular incomes and high levels of poverty.

CHAPTER 2

RESEARCH METHODOLOGY

2 Introduction

This chapter describes how the research for this dissertation was undertaken, using both quantitative and qualitative research methods, and secondary research that included the literature review. However, before going into detail of the methodology used, the introduction to this chapter will outline the reasons for the choice of the organization studied.

2.1 Organization studied

In 1996, the Strauss Commission, which was concerned with the provision of rural financial services, indicated that economic and social development could occur as long as there was a system that could provide for secure savings mobilization and access to loans for local productive purposes for rural and urban populations (Strauss Commission, 1996). FinaSol is a not-for-profit organization established to promote and support the development of Financial Service Co-operatives (FSC).

The relationship between FinaSol and FSC is that of a "franchising system", whereby FinaSol provides the training and necessary tools to support the FSC. Its mission is "to empower communities to achieve and maintain cop-operative self-reliance and economic growth through the development of Financial Services Co-operatives" (FinaSol, 2000). Financial Service Co-operatives are *community-banking structures that provide a range of financial products for* poorer people and those in the informal economy. An interesting aspect of this initiative is that it is donor driven to service the needs of the poor and the 'unbankable.' As has been indicated, FinaSol was established to enhance and support the emergence of Financial Service Co-operatives, which are "banking" structures based on the Raiffeisen Banks used by the German farmers and poor

people who were experiencing the same problems that rural South Africans are struggling with (FinaSol, 2000). FinaSol has been registered as a not-for-profit company under Section 21 of the South African Companies Act. There is a franchise agreement between FSC and FinaSol. FinaSol only helps in "kick starting" the FSC's to cover operating costs and this involves a loan. FSC are also registered formally as co-operatives and fall under the ambit of the South African Co-operatives Act (Act No.91 of 1981) and the South African Reserve Bank Notice 327 of 1998, which permits FSC to take deposits from individuals and groups of people.

Given these formalities, FSC is able to provide a range of financial services, which are savings, orientated. The key products offered are shares, savings and loans, from small to large amounts, funds transmission and other financial services such as insurance products. I looked closely at the aspects of insurance products to explore whether FSC could build a sustainable health insurance scheme for its potential clients. Tools were identified which can be used to access such information. The present study was conducted at Tseki and Makwane villages, where FSC is operating.

Tseki branch was established first and Makwane branch has just been established. The distance between the two villages is approximately 20 to 25 kilometers. Both villages are peri-urban, even though there are some rural features (mud houses). Makwane is far away from the capital Phuthaditjhaba, whereas Tseki is very close to the capital. Tseki has more members because it was established first. The Tseki board of directors is more enthusiastic about the running of the business than that of Makwane. This was evident when I met with the Tseki board, whereas it was difficult to meet the board from Makwane, as they were busy with their businesses somewhere else.

2.2 Gaining access to the subjects.

One of the problems that most researchers face is gaining access to the subjects (Mouton *et al.*, 1990: 206). Gaining access to an area such as Qwaqwa, which has a long history of Chiefs 'Marena', was not going to be easy. In trying to deal with this problem, I made numerous calls to FinaSol, followed by a formal letter (Appendix 2). After FinaSol agreed to the study, numerous calls were made to the Chairman of FSC in the villages around Qwaqwa namely Tseki and Makwane. The intention was to negotiate access to the members through the chairpersons.

Having spoken to FinaSol and the FSC's chairperson in Tseki, I was invited to attend one of the monthly meetings on 9 September 2001. The intention of the meeting was to explain to the members the importance of the study to be undertaken and to ask for co-operation. A number of questions emerged from this meeting.

The main question was what happens when the whole household got sick? This was a very important question as it related more to the sustainability of such a health insurance scheme because poor people's risks are so concentrated. As the importance of health insurance was being explained, I realized that very few people understood, or had not been exposed to the idea of, insurance and how it works. I realized that everybody wanted to volunteer their time to participate in the study because of the significant contribution it could bring to them. I explained that not everyone would be chosen to be part of the survey. As Mouton and Marais (1990) contend, it is vital that a rapport is established between the researcher and participants to dispel any distrust that might occur (Mouton and Marais, 1990: 92). I am of the view that any distrust was dispelled during this meeting.

2.3 Sampling

Sampling is used to choose a subset of units of analysis from a population (Smith, 1975:105, Mouton *et al.*, 1990: 208 and Balnaves *et al.*, 2001:90). There are different kinds of sampling methods and each has advantages and disadvantages. The intention of sampling is to ensure that there are no biases in choosing the subjects and also to make the study representative. The researcher chose to use systematic sampling.

I had to choose a number of registered members using systematic sampling described by Smith (1975: 121). FSC gave me a list of all 225 registered members. I needed a sample of 34 and I decided to interview every 7th person. I tried to interview every 7th person but could not find those sampled because they were working out of Qwaqwa. I then called for volunteers who were other registered members of FSC. The implication of the sample procedure adopted for this study is neither representative nor purposive.

2.4 Data collection method

To develop a good understanding of the subject matter, the literature was thoroughly reviewed. It was used to develop an analytical and conceptual framework. I designed a semi-structured-interview based on the questionnaire, to understand and explain the social structure (Appendix 3). In a semi-structured interview, the researcher has the freedom to change the sequence of questions and, in most cases; questions are open-ended and not predetermined. Bateson (1984) says that the interview process allows for the researcher to probe and clarify questions and this helps the researcher to keep the interviewee on track (Bateson, 1984: 5). The subjects mostly had a limited understanding of English. However, since I speak Sesotho, it was easy to probe and clarify questions. According to Bateson (1984), a researcher can accumulate a wealth of information regarding the interviewee from direct observation (Bateson, 1984: 15). I was also observant.

2.5 Data analysis

The Statistical Package for Social Scientists (SPSS) and MS Excel were used to analyze the raw data collected from the thirty-four (34) cases. Both the MS Excel and SPSS are complementary in plotting graphs to illustrate the results (Balnaves and Caputi, 2001: 127).

2.6 Limitations of the study

During the proceedings of the FSC monthly meeting, it became clear that people had no understanding of insurance as a concept. After explaining the importance that health insurance could play in their lives, they began to show more interest in the subject. What they had in mind was that health insurance would be available very soon, as part of the financial products of FSC. In fact, they *demanded* that it be included in the financial products of FSC. They did not consider their ability to pay for health insurance packages, including the feasibility and desirability for such a scheme. This study created the wrong impression that FSC would offer a sustainable Community Based Health Insurance Scheme very soon.

Furthermore, the fact that most registered members of FSC wanted to volunteer to be part of the study raised the expectations of these people with regard to the development of a Community Based Health Insurance Scheme. Most of the volunteers were those who were vocal at the meeting and this might cause a bias in the research.

The small sample size, and absence of any sampling procedure renders the quantitative approach that was adopted meaningless, while the lack of depth in the interviews that were conducted does not permit qualitative analysis. The sex ratio of the sample was not a true reflection of FSC membership, in which, overall, there were more females than males. The respondents worked mainly in the informal sector. There has been some lack of agreement about the constitution of the informal economic activities (Tickamyer and Wood, 1998). I

approached the respondents as the undifferentiated mass of poorer people. It was clear from the study that there were people in the informal sector who earned more than people in the formal sector. Within the informal sector itself, there are those who could afford Micro Health Insurance and those who could not. The main limitation was that I could not get reliable figures about the levels of earnings, which would be the key element in assessing the viability of a Community Based Health Insurance Scheme.

2.7 Conclusion

The chapter has described how the research was undertaken in Qwaqwa to elicit whether FSC could develop a Community Based Health Insurance Scheme in an area that is characterized by a high unemployment rate, lack of health facilities, irregular incomes, emergence of chronic diseases and a decline in public health spending due to decline in user fees. In gathering this information, thirty four (34) registered members of FSC were interviewed. Furthermore, as one component of information gathering, a literature review was undertaken to learn from previous experiences regarding the development of a Micro Health Insurance Scheme. The theoretical framework for the investigation of a Micro Health Insurance Scheme was centred on Micro Finance as a potential provider of Micro Health Insurance product. Micro Finance Institutions emerged as a vehicle to help the poor to start up their own small business enterprises. Micro Health Insurance is designed to insure the poor against the risk of ill-health during the business enterprise development. Chapter 3 provides the conceptual framework for the study.

CHAPTER 3

THE POOR, RISKS, AND MICRO HEALTH INSURANCE

3 Introduction

The intention of this chapter is to provide the analytical framework used in designing the study, themes and questions developed for fieldwork. Micro Finance Institutions are being established to offer loans to poorer people and those working in the informal sector (Hulme and Mosley, 1996, Rutherford, 1998, Rhyne, 1998, Wright *et al.*, 1999, Morduch, 2000, Mayoux, 2001, Lund and van der Ruit, 2001). Micro Finance Institutions discovered that their potential clients were spending much of their loans to cover health-related expenditures. In fact these loans were meant to be for business enterprise development. When people take out these loans, they have to repay them with interest.

Micro Health Insurance seeks to provide protection for potential clients against household income shocks arising from health-related problems, so that they are able to repay the loans (Brown and Churchill, 1999, Hulme, Matin and Rutherford, 1999, Brown, Green and Lindquist, 2000, Chen and Morduch, 2000). In this context, there is an increasing tendency from the World Bank and other international institutions to use the concept of risk and vulnerabilities to understand poverty (Holzmann and Jorgensen, 2000).

The concept of sustainability within health insurance systems is based on the idea of risks. It is assumed that if people can have a form of social protection like health insurance then some of the risks might be mitigated. Holzmann and Jorgensen (2000) elevated social protection to the level of Social Risk Management. They argue that the Social Risk Management conceptual framework provides a comprehensive view of poverty reduction, which takes

account of other sectors in the economy (including the informal sector). Social Risk Management framework, as they argue, will assist in analyzing a country's overall efforts to help its people manage risk well. According to Holzmann and Jorgensen, this is a universal framework that is applicable to all countries. If this is the case, why is there deepening poverty and great inequities in accessing affordable health care in the presence of Social Risk Management?

The impact of Micro Finance in helping poorer people has come under attack and the linkage between Micro Finance and Micro Health Insurance is highly technical and questionable (Brown and Churchill, 1999). If Micro Finance Institutions are becoming unsustainable, and at the same time adding Micro Health Insurance as an innovative way of social protection, may not Micro Health Insurance be unsustainable too? This section does not intend to provide answers to that question, but it will outline the Social Health Insurance policy in South Africa, which, if implemented correctly, could be a mechanism with which Micro Health Insurance schemes could link. Chapter 3 describes the problems, which have been found internationally, with developing Micro Health Insurance Schemes. These sections set the context from the final section, where an explanation is given of the key questions posed to prospective beneficiaries of a Micro Health Insurance Scheme.

3.1 Questions and themes

New initiatives are started by particular agencies, with a particular target group in mind, rather than approaching clients of Micro Health Insurance as a mass of undifferentiated poor people. It is helpful for an organization that wants to set up a health insurance scheme to know:

(1) What are the occupations of their prospective clients?
(2) What is the nature of risks faced by their prospective clients?
(3) How do they manage these risks/ sources of dealing with events?
(4) What are the patterns of use of existing health services?
(5) What is the present savings behaviour?

(6) What are their perceptions with regard to access and use of health institutions?

(7) What are their health fears?

(8) Are the potential clients aware of health insurance and its potential in enhancing the financing of the health sector?

(9) What are the chances of the sustainable Micro- Health Insurance scheme looking at who can provide the service and what the short-and long-term repercussions of not providing health insurance will be?

3.1.1 Types of occupational employment

A Micro Finance Institution is typically set up to help people who are mainly informal workers (Hulme and Mosley, 1996, Rutherford, 1998, Rhyne, 1998, Wright *et al.*, 1999, Morduch, 2000, Mayoux, 2001 and van der Ruit and Lund, 2001). Micro savings and loans are offered to start or enlarge a business. Micro Health Insurance is offered to insure against ill-health (Hock, 1996, Brown and Churchill, 1999, Hulme, Matin and Rutherford, 1999, Brown, Green and Lindquist, 2000, Chen and Morduch, 2000). The type of occupational employment may be an indication of the risks that potential clients may be faced with and the occupational exposure to such risks. People in the informal economy normally work under harsh conditions, with unsafe machinery, traffic hazards, poorly ventilated rooms and an unhygienic environment. The combination of these risks will undermine the goal of financial sustainability within the health insurance scheme.

3.1.2 Nature of risks faced by prospective clients

The question sought to identify a set of interrelated risks that affect poorer people. Besides the idea of health insurance being based on risks, complex and interrelated risks can impact badly on the sustainability of any health insurance scheme (Wright, 1999). Risks are factors beyond the control of the affected individual or household. They can result in the temporary or permanent disruption of the functioning of the household; to such an extent that the income stream

required meeting the household's basic needs can no longer be maintained (Wright, 1999:1). Furthermore, Lund and Srinivas (2000) say that these risks not only adversely affect the income flow of the workers; they often simultaneously raise expenditure on the lowered income. The concept of risk is central to the concept of Micro-Finance. Lund and Srinivas point out that "Micro Finance to enterprise provides reliable, long strategy to risk reduction both *ex ante* and *ex post*" (Lund and Srinivas, 2000: 90). But how they are related is problematic. Wright (1999) emphasizes that it is important that Micro-Finance Institutions analyze and understand these differences [in types of risk] in order to be able to design systems of products and services that are appropriate to the risk management needs of poor people (Wright, 1999:1). Common risks that prospective members of health insurance scheme face (whether in the formal or informal economy, as identified by Lund and Srinivas) are:

Ill health: Illnesses lead to lower productivity and increase the possibility of losing a job due to missed days at work

Reproduction and child rearing: This also creates problems because mothers have to spend some of their monies on childcare and loss of income during maternity.

Death: Funerals are becoming a costly business in South Africa and even the poor are spending huge amounts of money to have a 'decent' funeral for their loved ones. The loss of a breadwinner lowers the income of the households and might push households deep into the poverty zone.

Disability: Even though being disabled does not necessarily mean unable, people with disability are excluded from formal employment activities

Loss of assets: Municipal authorities often harass people in the informal economy and their belongings are taken away. Some lost their livestock due to

floods, like the once that happened in the Free State during September 2001 when the present study was undertaken. Others lost their assets due to fire, theft and drought.

Increased expenditure for social events: Events like circumcision/initiation ceremonies; marriages and celebration costs create economic stress for many households and individuals. They sometimes erode the income for household. Building a sustainable health insurance scheme in the presence of these events may be risky, more especially if prospective clients do not consider ill-health a major hazard. The implication is that people may not prioritize their health care, which will make it difficult to convince them to belong to a Community Based Health Insurance scheme.

3.1.3 Management of risks

Risk management is a very important aspect in the daily lives of the majority of people (Holzmann and Jorgensen, 1999, Wright, 1999 and Lund and Srinivas, 2000). It empowers people to control their lives in a very productive and less stressful manner. Poorer people are faced with a number of risks. What is important to understand is how they cope and manage these risks. In conceptualizing Social Risk Management, Holzmann and Jorgensen (2000) suggest that a distinction be made among three dimensions: the types of risk which determine the form of intervention, the main strategies in dealing with risks, and the level of formality at which risk management takes place. The present study focused more on the people in the informal sector.

Determining how people manage their risks gave an indication of which types of risks poorer people are able to deal with easily and which types put them into even deeper financial crisis. The framework offered by Rahman and Hossain (1992), looks at the analysis of risks and how risks can be counteracted. The framework identified three components of risks: crisis risks, life-cycle risks and structural risks. All of these risks require careful planning. The question is

whether poorer people are able to plan in time to avoid these risks. The answer may be no. For example, people may not contribute to a health insurance scheme due to the fact that they may only access the benefits when they fall sick and need medical care. This question was raised to explore whether insurance could be used as a mechanism to mitigate risk and whether people can accept the idea of insurance as a risk management tool.

3.1.4 Patterns of use of existing health services

A Micro Health Insurance Scheme will have to locate itself and its products in the surrounding "health market", whether public or private. Poorer people can access different kind of health services in their surrounding areas (Hirschowitz and de Castro, 1998:100). Even though the majority of the poorer people rely on the public sector for their health, there are also private practitioners and traditional healers. This question sought to understand areas where people felt that they received care based on the quality, convenience, affordability and the frequency of their visit. In building a sustainable health insurance scheme, it may be ideal to channel potential clients where they feel that they are being treated with dignity and respect and where they are not made to feel that they are poor.

3.1.5 Perceptions of health services

The present study sought to examine the extent of access to, and satisfaction with, the health services. The goal was to assess patient satisfaction and perceptions of health service in an area such Qwaqwa. Perceptions concerning health services differ (Hirschowitz and de Castro, 1998 and the South African Health Review, 2001: Chapter 11&16). What was important for the present study was how the community perceived the health services within their area. This is important, particularly if organizations and government are contemplating building sustainable health insurance schemes for poorer people. These perceptions can either make or break any intended policy direction. If people perceive that health institutions offer value for money, good, friendly service,

caring doctors and nurses, and when people feel they are treated with respect and dignity and are not made to feel bad about being poor, then it may be much easier to build a health insurance scheme. On the other hand, if people feel that waiting times will be too long, that they will receive rudeness and be made to feel that they are poor, then health insurance schemes may not be successful. Questions in this regard help to estimate the cost of providing alternatives and improved services.

3.1.6 Savings behaviour

Saving is an indicator of collateral status, which shows the ability of people to save (Wright, 1999). Much can be learned about the potential clients to contribute, by looking at their previous experience of trying to save. The intention of this question was to identify and depict whether poorer people are able to save money in this era of social risk management and micro finance. This is of particular importance because health insurance is a form of short-term savings. If people are unable to save on a regular basis using a Micro Finance Institution and if Micro Insurance is tied to savings it may be impossible for Micro Insurance to succeed under irregular savings behaviour. This will impact poorly on the sustainability of any Community Based Health Insurance Scheme.

However, there are many innovative ways in which people can save their money. Poorer people use various types of informal financial organization to save for certain risks. Rotating schemes (stokvels) are also famous in South Africa and are seen as informal savings schemes. However, the system of informal lending has its own advantages and disadvantages that are very complex and beyond the scope of this paper. If poorer people can use rotating schemes and burial societies as a way to save for certain risks, could it also be possible for them to save for their health care by means of health insurance?

3.1.7 Access and utilization of health care

Access and utilization of health care is an indication of the way people are able to access and utilize health care in a manner that is affordable (Hirschowitz and de Castro, 1998). The rationale behind this question was to explore whether health services are easily accessible to the poorer people in an area such as Qwaqwa. The accessibility of health service also contributes towards the cost of accessing health care services. Health insurance schemes may not be sustainable or receive support when members are going to travel for hours before they can access the next health service. At the moment, however, even basic medicines and ambulance services are not within reach of a great part of the majority of the South African population, particularly in areas such as Qwaqwa (Edwards – Miller, 1998 and SA -PPA). Clearly, the sustainability of health insurance schemes lies around the ease of accessing health services. Furthermore, price is the major obstacle for access to many essential drugs, since most drugs are priced far beyond the means of individuals or even of governments. Health insurance can be sustainable if people are confident that it will be easy for them to access health services and high quality and affordable essential drugs.

3.1.8 Health fears

The question of health fears relate closely to the problems associated with building a sustainable health insurance scheme. Due to the increasing burden of disease and the emergence of new diseases like HIV/AIDS, people may join the schemes in fear of these diseases (adverse selection). The financial impact of chronic diseases on Micro Health Insurance has not been assessed. If potential clients are going to join the schemes knowing exactly what their health status and medical history is, then such schemes may not be sustainable in the long run due to the high cost of claims.

3.1.9 Awareness of health insurance

Awareness of health insurance relate to consumer education about health insurance principles. The more potential clients are informed about health insurance schemes, the higher the chances that they may join the scheme. However, if the potential clients are illiterate, then it may be difficult to explain the rationale behind a Micro Health Insurance Scheme.

3.1.10 Chances of a sustainable Micro- Health Insurance

This question sought to understand how easy it could be to build a sustainable health insurance scheme. As Chapter 2 indicated, most of the people interviewed were in the informal economy, which is characterized by irregular incomes and harsh working conditions. What would the potential ability to contribute to a scheme be? Surely, building a sustainable health insurance scheme under those conditions may be a mammoth task. The implications for not building mechanisms to help the poor may have unintended consequences. This question also ties in well with the current developments from the World Bank and other international agencies to link Micro Health Insurance to Micro Finance Institutions.

3.2 Micro Finance and Micro Health Insurance

A Micro Finance Institution (MFI) is a mechanism to provide credit and this credit can enable poorer people to attain greater financial leverage and control over their environments (Morduch, 1999). MFIs can be seen as one of the possible providers of insurance services and a mechanism for social protection. In an era of increased vulnerability and risks, coupled with harsh working conditions in the informal sector, Micro Health Insurance has been considered as one form of social protection and Micro Finance Institutions are considered as the preferred providers of this service. In fact, MFI's are being encouraged to add Micro Health Insurance as a new portfolio of products in their financial services (Holzmann and Jorgensen, 2000, Chen and Morduch, 2000 and Bennett and Gilson, 2001). This

can be seen from the Social Risk Management, which also encourages risk mitigation in a form of Micro Insurance for health. The key question to ask is whether Micro Health Insurance is the appropriate mechanism for risk management for poorer people. There has also been a debate around Micro Finance and its potential to reach the poor and there is going to be a debate on linking Micro Health Insurance to Micro Finance (Chen and Morduch, 2000). For example, in Micro Finance today, the split continues between those in the "poverty" camp and those in the "sustainability" camp (Rhyne, 1998:6).

There is a move towards 'best practices', as enshrined in the "Win-Win" proposition. The assumption around the "Win-Win" proposition is that MFIs that follow 'good banking' will also be those that alleviate most poverty. Murdoch explains this proposition clearly and with caution; he says that the proposition assumes that by 'eventually eschewing subsidies and achieving financial sustainability', Micro-Finance Institutions will be able to grow without constraints imposed by donor budgets (Morduch, 2000:617). The other question that can be asked is to what extent health insurance can be linked to Micro Finance? Is there a real emotive appeal to link insurance to MFI's?

The debates indicate that MFI's are finding it very hard to maintain financial sustainability. It is likely that the addition of another portfolio of product like health insurance could exacerbate the financial soundness of the MFI, especially if MFIs are increasingly becoming financially unsustainable. However, the growing international literature insists that a Micro Finance Institution (MFI) has a vital role to play in strengthening the ability of households and individuals to set up enterprises of their own (see, among others, Morduch, 1999:3, Matin *et al.*, 1999: 7, Morduch, 2000, Lund and van der Ruit, 2001: 10). Advocates of both Micro Finance and Micro Health Insurance stress that Micro Health Insurance could be seen as a way of extending health care coverage to the poorer population, to help them to be productive after setting up their enterprises. In fact, the idea behind the MFIs is that mainstream financial institutions, are firstly, too expensive

for poorer people and, secondly, they make it difficult for people to save and/or take loans. The creation of Micro Health Insurance is based on the assumption that formal health insurance mechanisms are too expensive for the poorer people and, therefore, inaccessible to poorer people. According to Lund and van der Ruit, MFIs might also be considered to have a key role to play in women's empowerment, by giving poorer people access to independent sources of income. Similarly, Micro Health Insurance is considered to be empowering women to make informed choices about their health care. However, a cautious approach is needed when looking at this issue. Mayoux suggests that the solidarity basis of a Micro Finance scheme may carry a cost for women (see Mayoux, 2001: 436) and this may also apply to Micro Health Insurance. The poor in the past have been considered "unbankable". Most of the poorer people have been sidelined from formal financial institutions and thus have been unable to develop a credit record, nor do they have adequate collateral.

The challenge for Micro Lending Institutions, as indicated by Lund and van der Ruit, is to keep risks and costs for both borrower and lender at a lower level in order to provide financial services that are institutionally sustainable and appropriate to the poor (Lund and van der Ruit, 2001). But how can that be achieved when MFIs that are reaching the poorest section of the population may become unsustainable, like the Rural Finance Facility in South Africa, which mainly focused on providing micro loans to poorer people? This may mean that if Micro Health Insurance is linked to Micro-Finance, and Micro Finance is unsustainable, automatically Micro Health Insurance may be unsustainable.

Clearly, one can think about risks in relation to the need for Micro-Finance. On the other hand, it becomes problematic in terms of choosing the kind of risks that can be covered by Micro-Finance. Chen and Morduch (2000) offer a framework of looking at the issue of Micro-Insurance and how MFIs can be role players. It is now widely accepted that people in both the formal and informal economies are faced with a number of risks. What is now needed is ways to manage these risks.

The main task facing NGOs, donors and governments is to create mechanisms to reduce the level of vulnerability and increase social protection. Chen and Morduch (2000:4) explain, "Risk management should not be understood narrowly as a means to ensure greater security and improved social protection to the informal sector". What they say is that it should be understood broadly, where enhanced security could also become the catalyst for other factors for addressing poverty, in particular improved opportunities and increased assets. Chen and Morduch go on to point out that, in the past, the poverty reduction discussion largely emphasized coping with risk. In coping, the poor are usually forced to rely on their reserves to counteract these risks.

Chen and Morduch (2000) suggest that new approaches to risk management that will be proactive, not reactive, are needed. The assumption is that proactive risk management strategies hope to manage risk ex-ante through risk mitigation (see Holzmann and Jorgensen, 2000, Lund and Srinivas, 2000:90). There are a number of successful MFIs such as the BancoSol of Bolivia and Grameen Bank of Bangladesh that are seen as meeting the client's needs. Chen and Morduch concluded by saying that addressing risk and risk management strategies might involve creating a mix of formal/informal institutions (Chen and Morduch, 2000).

The recent synthesis of 22 case studies of Mutual Health Organizations in six countries by Atim confirms that Micro-Insurance can extend social protection to disadvantaged sections of the population by mainly targeting people in the informal and rural sectors (Atim, 1998: x). Atim's study revealed that poor people with little or no savings can mobilize their small contributions to enable them to obtain access to health care of acceptable quality and that many MHOs are formed to a provide multitude of services to their members as part of a diverse strategy of struggle against poverty. They are an instrument of social protection for people who are not beneficiaries of current (official) regimes of social security. Lastly, the legal and institutional environment for the development of MHOs is characterized mainly by self-regulation, the presence of a number of promoting

institutions and government interest in their potential (Atim, 1998: 48). In another African region, the study by Kiwara showed that a formal social security system has not been established in Tanzania and more than 85% of the population is in the informal sector (Kiwara, 1999). Kiwara says that a number of social security systems were introduced to redress the situation, but they have failed or excluded the poor. However, Kiwara, who started the UMASIDA Mutual Health Insurance Scheme, established by the International Labour Organization (ILO), holds that the scheme will ensure accessibility to health care for the poorest of the poor. Recent international evaluation of the scheme shows that it is very popular among the poor and has a great role to play in health sector financing. What is not provided in these schemes is an insight into poverty outreach and sustainability and these are the key focus points of the present study.

Lund and Srinivas (2000) showed that there are innovations in social protection for the informal economy. Their study examined about seven cases from different countries. The main conclusions were that, large schemes depend on the voluntary contribution of time by poor people, schemes find it very difficult to be sustainable and large *and* that the State plays an important role in support for most schemes (Lund and Srinivas, 2000:61). Furthermore, Dror and Jacquier (1999) are confident regarding the concept of 'Micro Insurance'. They say Micro Insurance plays a very important role in the lives of the poor people. The suggestion by Chen and Morduch of creating a hybrid of formal and informal institution should be explored. For example, Micro Health Insurance (informal) can be incorporated into a Social Health Insurance (formal).

3.3 Social Health Insurance

Social Health Insurance is considered as one possible health financing strategy. The South African government has been considering Social Health Insurance as an option to mobilize resources and to address inequities. The concept of Social Health Insurance (SHI) is based upon the sharing of risk or the pooling of risks, that is the incomes of those who enjoy good health today, probably because of

their high incomes and the concern for their health and who do not use health services, should help supplement the incomes of those who fall sick and need help (see Normand and Weber, 1994 and Zigora, 1996). The assumption here is a very reciprocal one, or 'quid pro quo'. For example, it is assumed that those who are healthy now will also be entitled to have a portion of their health expenses covered by others, should they fall sick tomorrow. There are a number of characteristics that are related to SHI schemes, as identified by Normand and Weber, 1994: 13, Normand, 1999:865, Doherty *et al.* 2000: 171 and Thompson, 2002: 3. These are:

- The Social Health Insurance is financed through the payroll contributions that are collected from the employees and the employers
- Social Health Insurance does not provide universal coverage, it covers those who are formally employed
- It is legislated by government and requires regular, compulsory contributions by members
- Eligible members cannot opt out of a scheme or be excluded by the scheme
- Premiums are calculated according to ability to pay (i.e. according to income)
- Benefit packages are standardized

What these authors are saying is that when these features are collective, they develop huge 'risk pools', where a consistent membership of contributors and their dependents cross-subsidize the healthcare of those in need, such as the elderly, sick and poor, with premiums paid by the healthy and wealthy. Several countries in Eastern Europe, Asia and Latin America have experimented with SHI (see among others, Costa, 2002, Ensor, 2002 and Rossetti, 2002). However, in South Africa, the concept of Social Health Insurance (SHI) has been marked by controversy for some time (Doherty *et al.*, 2000: 170). Doherty and others point out that SHI was the 'talk of the town', in the late 1980s, as a mechanism the public sector could utilize to tie together resources previously spent in the private sector, thereby extending health care coverage. Since SHI can be used as a

policy option to improve equity, it has appeared as preferred policy option in a number of documents associated closely with the Mandela and Mbeki administrations. The evidence can be found in a number of official documentation that were behind the proposal of SHI. Some of the official documents proposing SHI is the ANC Health Plan (1994), White Paper for the Transformation of the Health System in South Africa (1997), Social Health Insurance System for South Africa (1997), Election Manifesto of the ANC (1999), the Health Sector Strategic Framework (1999 – 2004) and the Report of the Committee of Inquiry into a Comprehensive Social Security System for South Africa (2002). The resolution at the 2002 ANC 51st Conference, held in Stellenbosch, reiterated its support for a move towards a National Health Insurance system for South Africa (http://www.anc.org.za). In making sure that SHI does not remain merely wishful thinking, the government is still in favour of the SHI.

In 1997, SHI policy was formally adopted by the new government's Department of Health. This 1997 policy document spelt out three specific objectives. The first was to support the public health sector, which is seen as the backbone of the South African health care system. The second was to design a viable mechanism for fee collection in public hospitals, by ensuring that all formal sector employees and their dependents are insured for public hospital treatment. The third was to provide formal sector employees with government subsidized insurance cover for essential hospital care at low cost. The Report of the Committee of Inquiry into a Comprehensive Social Security System for South Africa has carried out some of these ideas recently. This Report, known as the Taylor Report, has proposed that South Africa move towards a National Health Insurance System, whereby every citizen, except the indigent, contributes towards the cost of providing universal health care. The Taylor Report proposed four phases to achieve National Health Insurance in South Africa. However, for the present study, only two phases will be dealt with, given their importance to the study.

Phase 1 is concerns the development of an enabling environment. This phase identifies key concerns that must be addressed for the realization of the move

towards universal coverage. What is critical in this phase, for the development of a Community Based Health Insurance Scheme is the realization that public hospitals must be reformed. If Micro Health Insurance Schemes are to be affordable, the use of public hospitals should be encouraged. Therefore it is critical that issues relating to quality of care, access to health services and human resource strategy are addressed in the public hospital system, for the development of any low cost medical scheme.

Phase 2 is concerns the implementation of preparatory reforms. The key advantage for the informal sector in this phase is the creation of the state-sponsored medical scheme, targeted at about six million blue-collar workers who cannot afford any medical aid. This will allow for the development of a low cost package, to be delivered via the public hospital facilities. At least it will be known that there is a low-cost package available to low income earners and the self-employed. These groups of people can join the scheme on a voluntary basis. The Department of Health hopes that this time, the Treasury and the trade unions do not undermine the efforts of the government in implementing SHI.

The Treasury has always said that it does not like the idea of earmarking tax for one specific function, while the trade unions argue that their members will not pay.for services that are available freely in public hospitals. Trade unions further argue that SHI is a way of making the poor pay for the poorest. Therefore critical stakeholders feel that SHI might be unable to deal with inequities in the health care sector. It may also be true that the Treasury underestimates the contribution that health can make to development. This point is further carried out in the Report of the Commission of Macroeconomics and Health (2001), which states "the importance of investing in health has been greatly underestimated, not only by analysts but also by developing country governments and the international donor community". There have also been some concerns about the concept of Social Health Insurance from various commentators. Carrin, De Graeve and Deville (1999) point out that several countries have considered

health insurance policies, without first examining whether the macro-economy can sustain the proposed policy framework. Their argument is that a social insurance system does not operate smoothly in an environment with a high proportion of informal self-employment (as in South Africa) or agricultural employment (also see Kutzin, 1996: 65). Secondly, they say that poorer groups may be left out when social insurance is employment- based, because insurance schemes may be established for specific groups such as civil servants, supported by public subsidies. Thirdly, they point out that social insurance may lead to excessive health service demand on the part of patients and whenever fees are used as a payment method, may induce excessive prescribing by providers.

According to Carrin *et al.*, these factors are important for the macro-economic environment, because health expenditures may increase at an alarming rate compared to the incomes and budgets of consumers, governments and employers (Carrin *et al.*, 1999: 860). Furthermore, Kutzin (1996) says that it is of vital importance that beneficiaries of SHI are literate and numerate (Kutzin, 1996: 68). In view of these arguments against SHI, one believes that they are blurred. For example, no research has been done on the 'optimal' or minimum level of macroeconomic environment that can support SHI. Secondly, the concept of SHI has been misunderstood; Social Health Insurance should be seen as a precursor for universal health coverage; not as an end to itself, but rather as a means to an end, with the end being a more equitable resource allocation mechanism. Given the extreme inequities between the public and the private sector, coupled with budgetary cuts in the health care sector, SHI still has a bigger role to play in the mobilization of resources and the creation of additional revenue for the health sector (Newbrander and Collins, 2001). The current proposals on SHI are not ambitious compared to the former ones. The focus is now on piloting the SHI to civil servants only. This process is underway through the Department of Public Services and Administration. South Africa may see a Civil Service Medical Scheme before the next elections. However, the growth of the 'atypical' is not to

be wished away. It should not be the focus right now, given the irregularities in the informal sector and the problems associated with building sustainable health insurance for the poor. The work of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa should be applauded (Taylor Report, 2002). Social Health Insurance should now be seen as part of the broader social security system in the country. Alone, SHI does not pretend to solve all the problems in the public health sector, but it should be seen as another way of trying to improve the public health care system and increasing access to health care. However, for the current SHI proposals to be successful, a policy environment must be created which will serve as a prerequisite for the successful implementation of SHI. The Taylor Report identified a number of policy questions that must be resolved and that are relevant to the Micro Health Insurance Scheme, such as like the centralization of the health budget, hospital reforms, the creation of a low cost environment and differential amenities.

3.4 Problems of building health insurance schemes

Building a sustainable health insurance is not an easy task, given the complexities in the process. There are a number of problems associated with the building of a health insurance scheme for poorer people, which can be understood with reference to general principles of insurance and actuarial science (Krauss, 1996: 2, Atim, 1998: 22, Dror and Jacquier, 1999: 88, Brown, Green and Lindquist, 2000:7, Brown and Churchill, 2000:2). Apart from extending medical cover to the widest population, the other goal of insurance is that of achieving financial sustainability. The goal of financial sustainability may be compromised when dealing with poorer people. There are numerous associated problems with offering insurance to poorer people.

3.4.1 Moral hazard

Health insurance schemes operate under conditions of imperfect information (encountering problems in identifying those risks across a large and diverse

population). They do not limit their activity to catastrophic risks or low frequency risks (being widowed, emergency hospitalization and serious illness). Moral hazard refers to the tendency of those insured to incur costs more intensively than if they were not insured. For example, people who know that they intend to be pregnant in a particular period might join the scheme to enjoy maternity benefits, especially when there are no 'waiting periods'. Some may join a scheme after they know they are sick. Therefore it is paramount to look at the risk covered and the availability of information to the insurer over the insured. Even though moral hazard should not necessarily be seen as a fraudulent use of the service, it might encourage people to seek treatment for a minor health condition that under normal circumstances they would overlook and this, in turn, affects the sustainability of health insurance schemes.

3.4.2 Adverse selection

Consumers may choose to take out insurance only when they have a high risk of claiming. For example, people with a probability of high health risks join, while the low risk groups do not join the scheme. Some people in the informal economy work in types of occupation (welding and motor repairs) that have a high risk of causing injury. Others live in conditions or provinces that are more prone to specific types of disease. In KwaZulu-Natal, where FSC is operating, there is a high rate of AIDS, cholera and malaria; people might join the scheme because of the high risk of the diseases. This may also affect the financial viability of the scheme because the premiums are set on the grounds of the whole population; if the actual subscribers tend to be those who will use the services more intensively than the average person, then the scheme might not be sustainable in the long run.

3.4.3 Cost escalation

Cost escalation refers to the danger that an insurance scheme will suffer from rapidly rising costs for a number of reasons linked to the behaviour of both the providers and the patients once such a scheme is developed. The concern here

is that providers will over-prescribe treatments, or may have incentives to make use of costly treatment mechanisms, under the impression that the scheme will foot the bill. There is no incentive for the consumer to challenge health procedures and practices prescribed for him or her, knowing that the scheme will pay.

3.4.4 Fraud and abuse

The insurance system can be open to the dangers of free riding. Free riding refers to the fact that self-interested individuals may wish to enjoy risk-sharing arrangements without returning the favour, or without reciprocity. People who are related to the subscriber can use the services in the name of the subscriber and therefore receive benefits without paying for them. That is why it is important to develop effective and efficient mechanisms to deal with the problem. Without proper systems for checking identities, insurance will always be open to such risks.

3.4.5 Underinsurance

People often buy less insurance than they need. If the person bears the consequence of such a decision, there is no risk to anyone else (either other individuals or the insurance). However, if someone is obliged to pay for uninsured services, then this situation becomes somewhat similar to free riding. Underinsurance can be avoided if the insurance scheme is not obliged to pay for anyone who is uninsured.

3.4.6 HIV/AIDS

The epidemic is posing serious threats for an insurance scheme, because it changes the demographic profile of the population. The problems encountered when building an insurance scheme are enormous and pose a serious challenge to Non Governmental Organizations, private insurers and governments, (see, among, others Visser, 1993: 132, Krauss, 1996: 2, Atim, 1998: 22, Dror and

Jacquier, 1999: 88, Lund and Srinivas, 2000: 56 and Bradshaw et al., 2000: 89). The financial impact of HIV/AIDS may be enormous on the Micro Health Insurance, if not properly assessed.

3.5 Conclusion

There are innovations that finance for the needs of people in the informal sector and poorer people. These innovations are built on the idea of the risks and vulnerability faced by poorer people. The formal financial institutions have sidelined the poorer people because of the concentrated risks that they are facing. One this risk is ill-health and lack of access to health services. Micro Finance Institutions are offering Micro Health Insurance as a form of social protection and an extension to health care services and to insure against the risk of ill health. However, Micro Health Insurance is a sophisticated undertaking and there are general problems of actuarial science that should be considered when building health insurance schemes for poorer people. Poorer people are not a mass of undifferentiated people and consideration should be given to that when building a sustainable Micro Health Insurance. There is room to manoeuvre from the formal sector to link with the informal sector. In this case, Social Health Insurance could be a platform with which Micro Health Insurance could be linked. This may lead to a more prospective cross–subsidy between the rich and the poor, the healthy and the sick and between the rural and the urban. Chapter 4 presents an overview of the status of the health care industry in South Africa and health factors that could affect the development of a sustainable health insurance scheme for poorer people.

CHAPTER 4

HEALTH CARE IN SOUTH AFRICA

4 Introduction

This chapter presents information on the status of the health care industry in South Africa, the problems faced by the poor in accessing quality care in the public hospital system in an area such as Qwaqwa and the health variables which will influence and affect the likelihood of setting up insurance schemes. There is a strong link between poverty and health. This section is about health status and poverty status.

4.1 Health care in South Africa

One of the determinants of health is how health care is structured. In South Africa there is a dual system of health care funding and provision. The private and the public sector health care systems tend to serve two different socio-economic groups. Some can access high-quality health care because of their ability to pay; others can only access poor-quality health service because of their inability to pay for health. The differences between the income levels of these groups have led to inequalities when it comes to health care. Most of the whites and the 'newly emerging' black elites have access to health insurance; the majority of blacks rely heavily on government-funded hospitals, traditional healers and community support for their health. The private health care sector can be seen as 'market–care' (ability to pay), whereas the public health sector can be seen as 'welfare-care' (van Rensburg, Fourie and Pretorius, 1992: 203). It is now becoming unacceptable that the public health care sector, which serves about 80% of the South African population, cannot provide high-quality health care, whereas the private health care sector, which serves at least 20%, can do so (van Rensburg, Fourie and Pretorius, 1992: 204). The Annual Report of the Department of Health (2001) states that the private sector, servicing some 20% of the population, absorbs 60% of all health spending. According to the Report,

the high cost of care in the private sector drives individuals who should be able to purchase health services to rely on free or subsidized care in the public sector (Department of Health, Annual Report, 2000/2001:7). The public health care sector in South Africa has the task of providing preventative and primary health care for the entire population. Given the scope of the public health sector, one would expect that more resources be channeled into this sector, as it covers a wider population.

4.2 Poverty and health

There is a strong link between poverty and health. Health can be viewed as an important asset of people who are living in poverty. It is widely accepted that development goals cannot be realized without a healthy society (Ron *et al.*, 1990:1). Therefore investment in health should be seen as a way of reducing poverty and improving economic development. People who are working and who do not have access to medical aid will cost a country or a company a great deal of money. Unhealthy people tend to under perform in their duties and responsibilities, leading to a decrease in productivity levels.

The SA-PPA provides numerous illustrations of the relationship between ill-health and poverty. The health problems listed in Table 4, as argued by May, are all related to poverty and demonstrate the higher prevalence of the disease of poverty, such as tuberculosis, diarrhoea and fever, amongst lower-income groups. In addition, May says that the "much higher rates of mental disability among the poor are an indication of poor mental health facilities, as well as the likely influence of violence and trauma on many poor people" (May, 2000:37).

An attempt was made in the Project for Statistics on Living Standards and Development (PSLSD) survey to incorporate a physical examination of children's heights and weights, to assess their health status. What can be seen from the PSLSD survey is the prevalence of under-nutrition in children. According to the Poverty and Inequality Report (PIR), the barriers that prevent the poor from

having access to high quality basic health services are specific to particular social and environmental situations. The SA-PPA studies showed that factors such as the cost of transport and physical distance from health facilities, the hours of opening of health facilities and the lack of support from the formal health system for informal systems such as Village Health Workers, were challenges and obstacles to accessing quality care. While the Free State statistics on nutrition are scanty, the national figures show that 39% of the population does not meet the 2000kcal/day requirement (PIR, 1998).

Table 4: National poverty profile of illness (%)

Illness	Ultra-poor	Poor	Non-poor	All
Tuberculosis	4.4	4.2	2.1	2.9
Diarrhoea	11.5	8.2	4.6	6.0
Fever	10.0	8.5	5.9	6.9
Physical disability	5.2	4.5	3.1	3.6
Mental disability	8.3	6.5	2.5	4.0

Source: (PIR, 1998)

4.3 The situation of health services

From her summary of some of the key characteristics of the health sector at the time of the 1994 elections, Budlender identified racial discrimination in access to health services and systematic under-funding of certain, usually poorer geographic areas like Qwaqwa as some of the factors that cause inequities in the sector. These characteristics are important in this study because they have impacted badly on the health of the poor and those in the informal economy. The poor have never known better health because of these characteristics.

4.3.1 Health service provision and utilization

Due to the legacy of apartheid, one would expect to see enormous geographic disparities in both provision and utilization. The figures for 1992 and 1993 show that *per capita* public-sector health care expenditure varied between provinces, the lowest was R137 in Mpumalanga and the highest was R491 in the Western Cape. There is also a vast difference in terms of population per clinic. Budlender (2000) points out that this number varied between 23 000 in KwaZulu-Natal and 6 000 in the Northern Cape. Even though the statistics are scanty for Qwaqwa, the fact that most of the people have to travel for an hour or more to reach the nearest health care provider indicates some of the disparities. There are also some backlogs when it comes to visits to doctors. To illustrate this point, McIntyre says that people who have medical aid visit a general practitioner 5-6, times a year whereas residents of the poorest districts in South Africa, who are more reliant on public services, utilized outpatient services (clinics and hospital outpatient departments), on average, once a year (McIntyre *et al.*, 1995 cited in May *et al.*, 2000:108). This shows that the poorest section of the population cannot realize the socio-economic rights, even though they are enshrined in the Constitution.

4.4 Health status and determinants

There are changes in the demographic profile of the country and that is coupled with a decline in the levels of fertility. Bradshaw and others warn that the triple burden of disease from a combination of poverty-related diseases, emerging chronic diseases and injuries might be the cause of the decline. The impact of HIV/AIDS epidemic on mortality and life expectancy is well documented. It is estimated that in the next 10 years six million South African will die from AIDS (Bradshaw *et al.*, 2000: 89).

4.4.1 Population

Population can be defined as all members of a particular group or a total number of people in a particular country. According to the 1996 Census, the South African population was estimated at around 40.1 million, after necessary adjustments. The mid year estimates for the 1999 showed an increase to 43.1 million people based on annual growth rates of 2.4% for males and 2.0% for females (www.statssa.gov.za/Statistical releases/Statistical releases.htm).

In 2001, when the study was conducted, South Africa had more females (51.7%) than males and it had a very youthful population, with 34% under 15 years of age and 7% over the age of 60. However, the HIV/AIDS epidemic will have an impact on the population pyramid and population projections. It is expected that the impact of AIDS will be greater on women and there will be a marked increase in the number of orphans (Bradshaw *et al.*, 2000: 90). HIV/AIDS will have an adverse impact in both income and health cross-subsidization of the scheme.

4.4.2 Life expectancy

Life expectancy refers to the expected time a person can live. Statistics South Africa estimates that the life expectancy in 1996 was 52.1 years for men and 61.6 years for women. Life expectancy is being reduced by the AIDS epidemic. Bradshaw and others say that life expectancy will drop to about 40 years by 2010, bringing it to amongst the lowest in the world. This will affect the risk-sharing concept of insurance, not only in terms of the costs of treating AIDS but also in terms of the number of years men live and the fact that women are dying even earlier, from AIDS. In Qwaqwa, it is apparent that men contribute significantly to household survival and should be the main contributors to the health insurance scheme. Therefore, if men are to die earlier, the financial sustainability of the scheme will be compromised.

4.4.3 Migration and urbanization

Migration is defined as movement of people from one area to another for better economic and social opportunities. Migration and urbanization have been prevalent in the Free State. The motivation for the movement of people is the search for economic opportunities. This has implications for the setting up of a health insurance scheme, for a number of reasons. Firstly, women are left with disproportionately large numbers of children who are staying in broken families. Secondly, there is a shortage of young adults in such areas. Lastly, apart from the skewed demographic profile, the pooling of risk of the wealthy, the healthy, the sick, the disabled and the elderly is affected, thus making health insurance impossible.

4.4.4 Ageing

Ageing is a natural process of growing. The demographic profile of South African population is completely different to that of wealthier countries, with respect to the proportion of elderly people. Only 5% of the population is over the age of 65%, years compared to 25% experienced in some northern countries. Most of the elderly are blacks, who are based in rural areas. Few of them are living in their homes and in old aged homes. The majority of the elderly missed the opportunity of having formal education as they were employed as domestic workers, or perhaps were 'garden boys' during the apartheid era.

A number of elderly live in poor conditions without basic facilities. This is another group of people who form part of the risk-sharing and risk-pooling concept. Therefore, in the design of health insurance schemes, one has to take into consideration the ageing population, in terms of the risk they face, their ability to contribute and whether the young and healthy will be pleased to cross subsidize for the elderly. However, with the high mobility of the younger population, elderly people still make important contributions in households.

4.4.5 Mortality and morbidity

To begin to understand whether an NGO could reasonably build a sustainable health insurance system, one must know what the mortality and morbidity patterns are in the client population. As van Rensburg *et al.* wrote: "morbidity and mortality data is also used as a yardstick when measuring the functioning, effectiveness and impact of existing health services, the success of immunization, counseling and health campaigns – specifically with a view to possible extension and improvement in the areas or sectors of the population needing it most." Morbidity and mortality outline critical information on the nature, operation and importance of specific risk factors, which play a role in certain disease conditions, especially in cases where there is a connection between a population's life style and living conditions, and a specific disease condition." (van Rensburg *et al.*, 1992: 126). In Qwaqwa, where people are living in harsh conditions and broken families, the intensity of morbidity and mortality might be high, thus affecting the financial strength of the scheme.

4.4.6 Child Mortality

Under-five-mortality reflects the probability of a child dying before reaching the age of five years. This is an important indicator of child health and development. The SADHS 1998 estimated that the under-five-mortality rate was 61 per thousand live births over the preceding 10 years. Table 5 show that the Free State has a higher child mortality rate than the overall South Africa Infant Mortality Rate. Furthermore, Infant Mortality Rate (IMR) is almost four times higher than that of the whites.

The reason why the Free State has a high child mortality rate might be the impact of under-nutrition or stunting, since children are unable to meet the daily-required calories (PIR, 1998). Insurance schemes entail different packages and benefits. People who will be part of the health insurance scheme might also prefer to cover their dependents and the child mortality can be a challenge for

such a scheme, because the rate is high in the Free State and this indicates the level of poverty in the Province.

Table 5: Infant and child mortality in the Free State and population group, 1994-1998.

Province	IMR/1000 live births	U5MR/1000 live births)
Free State	53.0	45.3
African	47.0	63.6
White	11.4	15.3
South Africa	45.0	61.0

Source: South African Demographic and Health Survey, 1998

4.4.7 Maternal Mortality

The Maternal Mortality Ratio (MMR) is a measure of the risk of dying from causes associated with pregnancy and childbirth and covers deaths during the period of pregnancy or within 42 days of delivery. So, as AIDS spreads, the rate of MMR will go up and health insurance might become less sustainable.

4.4.8 Adult Mortality

Apart from the impact of HIV/AIDS, poverty-related diseases such as TB are contributing much to the premature adult mortality in South Africa. Dorrington, in Bradshaw (2000), estimated that premature adult mortality (measured as the probability of a 15-year-old dying before the age of 60) has started increasing and will reach levels close to 80% within the next ten years (Dorrington, 1999 cited in Bradshaw *et al.*, 2000: 111). These statistics are crucial in terms of trying to set up any health insurance system in the country to avoid high costs of care.

4.5 Tuberculosis (TB)

Tuberculosis (TB) is a disease of the lungs caused by a bacterium and aggravated by smoking and unhygienic conditions. There is evidence that

tuberculosis was introduced into South Africa by the European colonizers (see van Rensburg *et al.*, 1992). The coal industries in the late 1800s were the main engines behind the spread of TB in this country. South African mines saw a tremendous increase in the number of mineworkers. It was in the 1900s that TB became a serious concern, as most people, and mostly black mineworkers, were infected. The Free State had a high rate of migration and mobility to farms and mines. The extent of occupational hazards in mines and farms is not known. However, in mines, TB is prevalent because of poorly ventilated shafts, stressful underground work, poor nutrition and overcrowding. These conditions are ideal for the spread of the causative bacterium. On farms, poverty, low wages and vulnerability to farmers' harsh practices might probably have led to the spread of TB and other diseases of poverty. TB is now receiving serious attention from the Department of Health[1].

4.5.1 HIV and AIDS

AIDS became noticeable in South Africa in the early 'eighties. According to van Rensburg *et al.* the HIV virus was discovered in January 1983. At the time of writing, AIDS is affecting every member of society who is engaged in unsafe sex, whether rich or poor, black or white, rural or urban. The prevalence of HIV has been rising at an alarming rate. There are marked differences between provinces. The recent Nelson Mandela/HSRC HIV/AIDS study revealed that the Free State, and not KwaZulu-Natal, has the highest prevalence of HIV/AIDS (HSRC, 2002). This may cause serious problems for FSC, as it has branches in both provinces. The contributing factor to the high rate of HIV/AIDS in the Free State might be the mining industry in Welkom and Orkney, long distance truck drivers who pass through the Free State and the high levels of poverty in the province. Therefore it is evident that the problems of poor health quality within the public sector are likely to become much worse as the AIDS epidemic worsens. The high volume of AIDS-related hospitalization is putting ever-greater

[1] The Department of Health declared TB a priority and introduced the Directly Observed Treatment, Short-course (DOTS) strategy in 1996 to curb the problem.

pressure on public sector resources. How will an already overburdened system deal with the pressures of more AIDS patients and how will this affect any envisaged Community Based Health Insurance Scheme?

4.5.2 Malaria

Malaria is the second most common notifiable disease in South Africa, the most common and dangerous one being TB. The incidence of reported malaria cases was 63 per 100 000 of the population in 1998 and this doubled to 120 per 100 000 in 1998 (South African Heath Review, 2000). Malaria is increasingly becoming an important health problem in parts of South Africa, affecting predominantly three malaria provinces, viz. KwaZulu-Natal, Mpumalanga and the Northern Province. There are no reported cases of malaria in Qwaqwa. However, it is a problem in KwaZulu-Natal and where the Financial Service Co-operative (FSC) is operating.

4.6 Public sector health care financing

According to the National Health Accounts, there is a need to look at the availability, distribution and allocation of human, financial and physical resources in reforming the public health sector (NHA, 2000). These factors are important for health policy reformers to understand the degree of sophistication, quantity and quality of the care supply. Thomas *et al.* (2000) said that the funding of the public health care system in South Africa has reached a *cul de sac*. They argue that even though there have been some efforts to improve equity in the funding of public health care during the inception of the democratically elected government, this trend appears to have reversed, when examining the trend of public sector health financing from 1992 and 1993 to 1997and 1998.

The National Health Accounts Project (2000) indicates that in 1992 and 1993 funding for Primary Health Care was substantial and that all provinces benefited from fair resources reallocation procedures, whereas the 1997 and 1998 era was characterized by declines in *per capita* public health sector funding. What can be

noted is that declines in *per capita* funding of public health care are becoming a trend in the democratically elected government. The Report emphasized that between 1996 and 1997 and 1998 and 1999 the total spending by the public health sector increased significantly, by R 1.7 billion. Nevertheless there was a slight decrease, year-on-year, in 1998 and 1999. In 1998 and 1999, public health financing expenditure amounted to 4.1% of GDP and 15.1% of the overall decrease of health expenditure on year-to-year basis. The Report points out that the decrease in funding of the public health sector for 1998 and 1999, noted above, appears to be due to declines in user fees from households and provincial revenue which is due to declines in real wages. The continuing budget decline in the public sector has unintended consequences. Given this scenario, the idea of building health insurance schemes for low-income earners becomes necessary. On the other hand, the poor quality of services in public hospitals might not be ready to support such a scheme or members will no contribute to knowing exactly that the public hospital system is declining and the growing perception that health care services are free for all.

4.7 Conclusion

The situation with regard to public health care in general is devastating. Standards are deteriorating at an alarming rate, while reforms are happening at a snail's pace. There is a strong link between poverty and health. The people who are most affected by declining budgets and poor quality of services are the poor. High levels of poverty and poor health status may pose serious challenges for building a sustainable health insurance scheme. Factors such as mortality, maternal mortality, migration, declining life expectancy and the triple burden of infectious disease should be addressed before any introduction of a sustainable Micro Health Insurance Scheme. The next chapter presents results from the survey that was carried out to explore the possibility of building a sustainable Micro Health Insurance Scheme and to address problems that were highlighted in all the chapters covered thus far.

CHAPTER 5

PRESENTATION OF FINDINGS

5 Introduction

As one component of the overall study, a survey was conducted of Financial Services Co-operatives (FSC) members in two villages around Qwaqwa in the Free State Province, over a period of two weeks. Chapter 5 presents the results of the survey. The interviews took place in the villages of Tseki and Makwane, where FSC was operating. The information presented in this chapter is based on the data collected from the 34 questionnaires in these two villages within Qwaqwa. Comparison between the villages will form part of the findings and discussion. However, because of the small sample size, the findings are not statistically significant. This chapter forms the basis for substantive discussion in Chapter 6.

5.1 Description of the respondents

Twenty-one and thirteen respondents were interviewed at Tseki and Makwane village, respectively. Chapter 2 described how the respondents were chosen. The researcher was given a list of registered members to choose from. Out of 225 members on the list, I then decided to interview every 7th member and was unsuccessful. I then called for volunteers who were also registered members of FSC. The implication for not following the adopted sampling procedure has made the data to be neither representative nor purposive.

5.2 Demographic and socio-economic profiles

The information below provides a socio-economic profile of the respondents. The focus is on the variables that may affect and influence the potential for building a sustainable health insurance scheme for poorer people.

5.2.1 Distribution by gender

There were 15 (49%) males and 19 (52.%) females. This does not represent the sex ratio of the FSC membership, in which overall there were more females than males. This greater proportion of female membership is similar to that found in the Rural Finance Facility which was a micro finance institutions similar to FSC (Lund and van der Ruit, 2001).

5.2.2 Distribution by relationship to household head

The majority of the respondents (59%) were household heads and the rest were wives (15%) sons (12%) and daughters (15%) of household heads. On the one hand, the status of head might have meant that the respondent was knowledgeable about family resources and the ability to make contributions. On the other hand, it is a reflection of the high unemployment rate that so many heads were at home during the day – pointing to probable low incomes.

5.2.3 Distribution by age

The age of respondents varied from 22 to 70 years. It can be seen in Table 6 that though there was a relatively even spread across the ten-year cohorts, the largest single category was 40-49 years and nearly two-thirds (21) were over the age of 40. This is thus a mature group that will be affected by a variety of health problems.

Table 6: Age of Respondents

Age of Respondent	N	%
20 – 29	8	24
30 – 39	5	15
40 – 49	9	27
50 – 59	5	15
60 – 69	6	18
70 – 79	1	3
Total	34	102*
	* >100 due to rounding	

5.2.4 Distribution by employment status and job description

Respondents were asked to identify the types of jobs they are involved in. Only the main respondent was asked for his/her employment status. The type of job is an indication of both financial and health security or threats. This also determines the degree of exposure to risk and opportunities. The types of jobs that the respondents are involved in are poor in terms of their potential for money generation. Their incomes will continue to be irregular and this will make it difficult for them to contribute on a regular basis to a health insurance scheme.

Table 7: Employment status and Job description

Employment Status and job description	N	%
Working full time	2	6
Informal Sector divided as follows	20	58
• Hawkers (street and schools)	3	9
• Hairdresser	1	3
• Spaza Shop owners	2	6
• Dress makers	4	12
• Motor mechanic	2	6
• Farming (Poultry projects)	4	12
• Construction work	3	9
• Supermarket owner	1	3
Pensioners	7	21
Unemployed	4	12
Other	1	3
TOTAL	**34**	**100**

5.2.5 Education levels

Respondents were asked what their highest standard of completed education was. This is important because higher education standards are considered as a screening mechanism for job employability. Furthermore, people with a high level of education may more easily grasp the principles and the importance of health insurance. Table 8 shows that 44% fall in the category of no education and primary education; however, even though there was a low employment rate, more than half the respondents (56%) had secondary and tertiary education. It may be easier for these people to be absorbed by the labour market and it may be easier to explain insurance principles to them and for them to understand.

Table 8: Education Levels

Level of highest education	N	%
No formal education	7	21
Primary education	8	24
Secondary education	12	35
Tertiary education	6	18
Incomplete tertiary education	1	3
TOTAL	**34**	

5.2.6 Household with a member with Standard 8 level of education

Secondary education is important because a person is able to read and write and this opens job opportunities for the person. Even though it is known that passing Standard 8 (Grade 10) or Standard 10 (Grade 12) does not mean getting a job, and even though "Bantu education" was poor, it can be assumed that someone with Standard 8 will have a sustainable literacy and will be able to read enough to do job searches. Standard 8, which is equal to 10 years of education, is taken as a basic level for employability in an open job market. Higher secondary standards are mostly used as a basic screening mechanism for a number of jobs in a context of such high unemployment. There is thus a chance of finding a job when a person has Standard 8 and higher. The longer that people are employed, the greater the chances of them contributing to a health insurance scheme on a regular basis. Respondents were asked to specify the number of people in their households who had at least Standard 8 and those who had Standard 10. Table 9 shows the number of households who had a member who had Standard 8 and higher. About one fifth (18%) of all households had no person with Standard 8 or higher. On the other hand, 62% of the households had between 3 and 6 people with a Standard 8 or higher. This holds positive hope of building a sustainable health insurance scheme.

Table 9: Household with Standard 8 and higher

Households with persons with Standard 8 and higher	N	%
No person with Standard 8	6	18
1 person	4	12
2 persons	5	15
3 persons	12	35
4 persons	4	18
5 Persons	1	3
6 Persons	2	6
TOTAL	**34**	

5.2.7 Monthly disposable individual income

Respondents were asked to indicate how much money they were bringing home at the end of the month. The rationale behind this question was to elicit whether people would be able to contribute to a health insurance scheme on a monthly basis. The question was poorly asked and answered. In general, however, the income levels were low. Exceptions were a supermarket owner and those where a pension combined with a formal job. Therefore the chances of building a sustainable health insurance may be minimal.

5.2.8 Household pension

Respondents were asked to provide information concerning the number of people receiving pensions in their households. Pensions are received on a monthly basis and are of known size and fairly reliable. More than half (56%) of households had no pensioners, nearly a third (29%) had one pensioner and five (15%) households had two pensioners. The old age pension is a form of social assistance that is paid out of general revenue. Pensions are a reliable source of

income, meaning that pensioners are able to contribute to the health insurance schemes if there are no other competing needs. A later chapter will return to this theme.

5.2.9 Household unemployment and employment

Most people in Qwaqwa are involved in informal economic activities. Furthermore, the unemployment and employment issues in Qwaqwa should be located within the overall South African unemployment situation. As has been indicated in other chapters, the high rate of unemployment might be a serious constraint in building a sustainable health insurance scheme for people in the informal sector. This will be dealt with in the discussion. Respondents were asked to indicate the number of people working in their household. The higher the number of people working within a household the higher the chances of financial security and ability to pay for health insurance. More than a third (35%) of the respondents said no one in the household was working, whereas 41% indicated that at least one person was working. The low levels of earnings are related to lack of economic activities in the area.

5.2.10 Gender of the head

The gender of the household head is used in some countries as a reliable indicator of poverty. This would not be a fully reliable indicator in South Africa. Although, in general, households headed by women are poorer, there is great variation depending on the age of the woman and whether rural or urban areas are being considered. In this study, the median age of female-heads was 52%, compared to the 42.2 median age of male heads. There was no difference in terms of the number of people and number of pensioners in households headed by both males and females. Male-headed households tended to have more people employed in the household than female-headed households. At the same time, there were few households headed by pensioners.

5.2.11 Household size

The study sought a demographic profile of households. The idea was to explore whether or not health insurance could be organised on a household level to increase the risk pool, so that the young and healthy could cross-subsidize the elderly and the sick. I was not rigorous about the definition of a household. I simply asked the main respondents to list all the household members. The average household size was 5.4 and the modal size was 6. The reason might be that two or more generations are living in one household, thus increasing the number of household members. Confirming the pattern in most South African surveys, rural households are larger. However, Qwaqwa looks like a peri-urban area and the increase in household size might be due to the lack of jobs in the area. In this case, more and more young adults are now staying with their parents, rather than having their own houses.

5.3 Health fears

Respondents were asked to identify the three health problems that they most feared and were asked to rank them in terms of the severity of their fear. The purpose of exploring fears in this study was to elicit information about people's perceptions of certain health problems and thus to be able to detect if or how the health insurance package could be designed to incorporate these fears. Table 11 shows that AIDS was mentioned 31 times as the most feared problem, followed by TB and Stroke. Sugar diabetes, cancer and asthma were also mentioned as other diseases that can have a lasting impact on the lives of the respondents.

Table 11: Three most feared health problems

Health problems	N	%
HIV/AIDS	31	92
Tuberculosis	12	36
Stroke	10	29
Sugar diabetes	7	21
Cancer	6	18
Asthma	5	15

5.3.1 HIV/AIDS

AIDS is the health problem feared the most and more than two-thirds (71%) identified AIDS as their worst fear. The fear of AIDS was almost identical in both villages. In Makwane, almost 69% (9) indicated AIDS as the worst fear and 71% (15) in Tseki also saw AIDS as a challenge. There was also little difference between males and females, with more than two – third of both males and females indicating that their most significant health fear was AIDS. It was expected that females in this small study would be more concerned about AIDS than men because they are more vulnerable to the disease. The fear reasons might differ. Those in their late twenties and early thirties wish to get married and have children, but fear that their partners are already infected.

5.3.2 Tuberculosis (TB)

Tuberculosis is a disease that mainly affects the lungs. People who are living in crowded houses like those in Qwaqwa are more prone to the disease. It is perhaps not surprising that TB was the second most feared health problem. TB is linked to AIDS. The estimation is that between 40 and 50% of people with TB in South Africa are co-infected with HIV and one-third of people with HIV are expected to contract TB before they die (Bramford, 1999: 322). Eighteen percent (6) of the respondents identified TB as their second worst fear. Four females and

one male ranked TB in the second order. Only one person in both Tseki and Makwane ranked TB as their first worst fear and four people ranked TB third.

5.3.3 Stroke

A stroke can be described as a brain attack and occurs when a blood vessel supplying oxygen and nutrients to the brain is blocked. Overall, stroke was seen as a slightly significant health problem, compared to AIDS and TB. However, the Southern African Stroke Foundation says that stroke is not given sufficient attention in South Africa and is one of the deadliest afflictions in the country (http://www.stroke.co.za/About_S_A_S_F/body_about_s_a_s_f.htm).

While stroke has decreased in other countries, South Africa is faced with an alarming increase in the incidence of stroke in all ages and population denomination

(http://www.stroke.co.za/About_S_A_S_F/body_about_s_a_s_f.htm).

5.4 Adequacy of health services in Qwaqwa

Respondents were asked on a scale of 1 to 5 (where 1 was "strongly disagree" and 5 "strongly agree" to rate the adequacy of health services in Qwaqwa. As emphasized in Chapter 3, the adequacy of health services determines how often people use such services. However, even if there are adequate health services, it does not mean that people will use them if they are not affordable. When people were asked about the adequacy of health services in Qwaqwa, close to four-fifths felt that Qwaqwa does not have adequate health services. How will health insurance succeed in an area where there are no adequate health services? It will not be ideal for FSC to create entitlements and not to meet the demands of its clientele. Health insurance might not succeed where there health services are inadequate.

5.2 Access to and utilization of health service in Qwaqwa

Not based on the five-point scale (see Appendix 3), but in a tabular form, respondents were asked to compare different components of the health services in terms of convenience, quality of care, costs and frequency of visits. Issues concerning convenience, quality of care, costs, access and utilization are important because they determine the level of health care in a particular area. The health policies of the African National Congress (ANC) government have put considerable emphasis on improving access to health care for every South African and also on reducing the increasing levels of racial and interprovincial inequities in access to health care. To set the context for the development of a low-cost medical scheme, the issues concerning access to health care were seen as a stepping-stone for the design of such a scheme.

5.5.1 Convenience of health services

Table 12 shows that respondents felt that clinics are convenient, as people do not have to take a taxi or travel a long distance before they can reach the clinics or traditional healers. Most of the General Practitioners (GPs) are located in Phuthaditjhaba and this requires people to spend money on travelling. There are no hospitals in Tseki and Makwane and people have to travel a long way (more than 20 km) to the local hospitals. If hospitals are to be used as a preferred service provider, they should be accessible to the community. Building insurance schemes, in the absence of a hospital in the vicinity of the community, might increase the cost of reaching health services because of increasing transport costs.

Table 12: Convenience of health services

Convenience	N	%
Clinic	31	91
Hospitals	3	9
GPs	6	18
Traditional healers	19	56

5.5.2 Quality of care

Respondents were asked about how the quality of care compared between different components of the health services. The intention was to assess people's knowledge and experience about the quality of care offered in different health services. This is important because people will expect a good quality of care when contributing to a Community Based Health Insurance Scheme. Table 13 shows that GPs provide an efficient and a high standard of care. However, it is surprising that traditional healers are regarded as providing a good quality of service, as compared to clinics and hospitals. The clinics and hospitals are under-funded and understaffed and hence there is a decline in the standard of health-care. It will be difficult to encourage people to belong to a health insurance scheme that uses clinics and hospitals when the standards of quality are poor and continue to decline.

Table 13: Quality of care

Good quality of service	N	%
Clinics	8	24
Hospitals	4	12
GPs	21	62
Traditional healers	16	47

5.5.3 The costs of health services

Respondents were asked about how the costs of care, compared among different components of the health services. This is because costs are associated with the ability to pay. In an era of high unemployment, clinics and hospitals are seen as the preferred health service provider. This stems from the announcement that free health care will be available for children under the age of six and for pregnant women. The free health care was extended to the wider population who make use of public primary health care facilities. Payments for health service at the hospitals are means tested. However, patients classified as indigent receive all the services free of charge, if they can provide proof that they cannot afford the fees due to unemployment or disability (Taylor Report, 2002: 87). Appendix 4 shows the classification of patients for the determination of fees (http://www.doh.gov.za/programmes/upfs-f.html).

The costs of GPs are seen as expensive with a consultation fee of around R80, excluding prescriptions. With traditional healers, it was mentioned that they could want a cow or sheep for the service provided and thus they are also seen as expensive. Why then should people pay for health care when they can access the health services at no costs? This is a daunting task for anyone who wants to build a sustainable health insurance scheme for poorer people.

5.5.4 Frequency of visits

Respondents were asked about how frequently they visited different components of the health services. This is important, because the frequency of visit relates to the cost and quality of care. Hospitals and clinics were visited more often than GPs and traditional healers. Respondents visited clinics and hospitals whenever they were sick. On average, females indicated that they were visiting clinics more than once a week and hospitals more that once a year. GPs and traditional healers were not frequently visited. The reason might be that the high rate of unemployment and the inability to pay for GPs and traditional healers was the

driving force for the use of State-provided health services. If the quality of service could be improved, people might be willing to pre-pay for their health.

5.6 Availability of medication

Respondents were asked where they got their medication. This is an indication of access to basic essential drugs. Almost four-fifths say that they bought their medication in the nearby pharmacy, and only 12% buy medication in the local shops. The other 9% rely on clinics to provide medication. In Makwane, everybody buys at the pharmacy, compared to only two-thirds in Tseki. About 19% in Tseki buy medication at the local shops and no-one in Makwane buys at the local shops. Almost 14% in Tseki get medication from the clinic, compared to none in Makwane.

5.7 Factors influencing choice of health facilities

Respondents were asked to mention factors that influence their choice of a particular health service. These factors are important in the marketing of the health institution and in exploring the perceptions of people with regard to health facilities. According to Newbrander and Collins (2001), poor perceptions of communities about the quality of care may result in decreased demand for health services. In building a sustainable Micro Health Insurance Scheme for poorer people, it would be ideal to deal with mis-perceptions and to create a positive picture about the health services. Once people are positive about the health services, it would be much easier to encourage them to use such services in a pre – payment system or user fee method. In the present research, three important factors in choice of health institution were quality of service, attitude and behaviour of health personnel and costs. Close to half said that the quality of service is very important, quality in this case meant availability of effective drugs, ambulances, cleanliness and hygiene, waiting periods and so on. Attitude and behaviour of health personnel is another important factor. Almost a quarter said that they want to visit an institution where they will be treated with respect and

care. The other factor is costs: almost 21% of the respondents say that they consider the cost of going to a health institution. Given their current financial status, they rely more on public hospitals and clinics, which charge lower fees or no fees at all (primary health care free at the point of service at clinics). The implementation of any low cost medical scheme will need to address the concerns of the consumers urgently.

5.8 User fees

Respondents were asked about how they pay for their health care. This is important, because poorer people normally find it very difficult to pay for health care at the point of service. This was to explore the extent to which poorer people are excluded from accessing basic health care in most of health facilities. The majority of the respondents say that they would have to use cash if they needed health care. Because they have irregular or no income, it is clear that the degree and the extent of exclusion from health services is very high. On the other hand, there is a potential to introduce health insurance, which will eventually reduce financial risk to individuals at the time of accessing health care. However, lack of income may reduce this possibility.

5.9 Savings

Respondents were asked to describe their experiences in trying to save money. Insurance schemes require people to make regular contributions. Much can be learned about the potential of clients to contribute, by looking at their previous experiences of trying to save. Asking about savings efforts gave an idea of the collateral status of people in terms of accessing financial products like insurance that may be tied to savings. It appeared that more than four-fifths have attempted to save money. More than three-quarters and more than four-fifths in Makwane and Tseki, respectively, have attempted to save. Close to half say that they saved for illnesses and other emergencies, such as funerals, that cause financial difficulties. Almost 18% saved for educational purposes. Only 6% saved money

to qualify for a loan and 15% saved to start a business. Those who had saved successfully were asked about why they had been successful. More than one-third mentioned financial management as the key to their success and 15% emphasized the use of formal financial institutions as the main contributor to financial success. The instability in the savings behaviour might indicate that even when health insurance is introduced people will still default, thus impacting badly on the financial sustainability of the scheme. The question asked was whether they have attempted to save. Most answers were yes but they had failed to save on a regular basis due to the fact that they had to withdraw money every time there was a crisis.

5.10 Willingness to use health insurance as a financing source

Respondents were asked whether they would consider health insurance as a health financing mechanism. This is critical, because it will limit the financial risks of accessing health care at the point of service. The majority of the respondents said that they were willing to use health insurance as a potential source of financing their health care. The willingness to pay for health care is there, but the key question is how health insurance schemes can be structured to provide for the needs of poorer people?

5.11 Risks

Respondents were asked to identify the risks that affected them on a daily basis. As explained in previous chapters, risks can put families in financial problems when not planned for. Health care as a risk can be financially disastrous to families if not planned for. Health insurance is a way of planning for health care. Table 14 shows risks that caused financial difficulties and Table 15 shows the type of risk experienced by households. It can be seen that funeral and educational costs can put families under severe financial stress. Loss of livestock and loss of unemployment are risks normally experienced by households. Most of the people derive their income from their livestock. If their livestock is always

being stolen, then the chances of them belonging and contributing to a scheme might be limited.

Table 14: Risks that causes financial difficulties

Risks causing financial problems	N	%
Education costs	11	32
Funeral costs	10	29
Food	7	21
Clothing	6	18

Table 15: Risks experienced by the household

Risks experienced	N	%
Loss of livestock	14	41
Loss of employment	11	32
Burglary	6	18
Disability	5	15
Crime	3	9

5.12 Sickness in the family

Respondents were asked whether anyone in their household had been sick in the past 12 months. Sickness in the family determines the level of health status of the members of the households. More than four-fifths said that at least one member of the family had fallen sick during the past twelve months. Almost half said that the cause of the illness was stomach pains headaches and body pains, and 27% said they were suffering from flu. These are minor sicknesses, but they can have devastating impact on the schemes if not managed properly. For example, there may be lots of claims for these minor sicknesses as they will be occurring continuously.

5.13 Birth in the family

Respondents were asked whether anyone had given birth in their household in the past twelve months. This is vital, since women face particular reproductive health risks. Births had taken place in just less than one-third of households. These births took place in hospitals and medical personnel were instrumental in giving birth. Of the five who responded, the money was taken from family coffers to finance the births. Health insurance can be useful in financing the confinement and childbirth.

5.14 Death in the family

Respondents were asked if they have experienced death in their family in the past twelve months. Death can cause financial difficulties for poor households. Funeral costs are now increasing at an alarming rate and everyone wants a 'decent' funeral for their deceased. Nearly one-third of households had experienced a death. The average cost of the funeral was R3 000. Close to 21% of those who responded said that they used burial societies to meet the costs of the funerals. Burial societies are obviously playing an important role in minimizing the costs of funerals for poorer people, but at the same the costs of funerals are high. Perhaps this could also be used as an indication of poorer people's ability to save.

5.15 Conclusion

The results presented showed that people are faced with a number of risks. Risks that cause financial difficulties are funerals, health care, lack of formal jobs, irregular incomes and the increasing rates of HIV/AIDS and other diseases. The results indicated that the poor have inadequate access to health services and that they rely on the public system, which is understaffed and overpopulated, although clinics *were* close by. People seem to feel happy about the service of GPs and traditional healers. There was at least one pensioner in one-third of the households. Twenty-one percent had no formal education. Employment levels

were very low, and people have some perceptions and fears about certain health facilities and particular diseases. On the positive side, high levels of secondary and higher education holds hope for building a sustainable Micro Health Insurance Scheme. The factors dealt with in Chapter 5 collect might impact negatively when building a sustainable health insurance scheme. Chapters 6 discusses these issues in detail.

CHAPTER 6

FINDINGS AND CONCLUSION

6 Introduction

Using results presented in Chapter 5, this chapter explores the possibility of building a sustainable Community Based Health Insurance Scheme for people in the informal economy who do not have access to formal insurance, or employment-based insurance. It also suggests policy options that can be explored to finance the health of the poor.

6.1.1 Concentration of risks

It can be seen that the poor are faced with a number of risks. These risks are concentration. The framework offered by Rahman and Hossain (1995) in Wright (1999), looks at the analysis of risks and how they can be counteracted. The framework identified three components of risks:

- Life-cycle risks
- Structural risks
- Crisis risks

In Qwaqwa, it is evident that the interaction of these risks has led to hardships and problems for households, because of the complexity of this risk environment. Even though these risks are interrelated, they will be discussed separately, in terms of how poor people respond to them.

6.1.2 Life-cycle risks

There are life-cycle risks that are related to the present study. These include birth, schooling, health care and death. Looking closely at these risks, it can be seen that it might be easy to plan and manage them, because of their predictability. Wright (1999) says that regular savings are the best possible way to manage these risks, as they need a substantial amount of cash in a very short

period of time. If these risks are not planned for, they can push families deeper into poverty. In this study, it was clear that the people are unable to save and, even if they tried, the money that they saved went to these life-cycle risks when they occur. In terms of deaths, which require a large amount of cash, it appears that burial societies are playing a crucial role, considering the high costs of 'decent' funerals at the present time in both villages. Research that examines the impact of HIV/AIDS on burial societies is needed. It might be possible that those who cannot afford to be members of burial societies are struggling with the high costs of funerals.

6.1.3 Structural risks

According to Wright (1999), structural risks occur when there are permanent or long-term changes in the national or global economies. Free State province, as part of South Africa, suffered from the implementation of the Growth Employment and Redistribution (GEAR, 1996). The intention behind GEAR was to encourage openness and market-friendly approach in the economy. However, water, health and education are basic necessities that should not be left in the hands of the private sector. Qwaqwa is lacking in terms of these basic services. There has been a budgetary cut in the health and other social services and this really exposes the impact of the free market economy. Risks that are faced by the Free State are a result of openness of the market that has impacted badly on the economies of developing countries. For example, people in Qwaqwa identified crime as one of the problems they faced. In a free market economy, crime can move from one country to another, and from one province to the next because of transport networks. There are a number of cases in which dagga is transported from Lesotho via the Free State and on to other countries or provinces. Therefore one can say that during apartheid and sanctions, crime was contained, but it is now open because of the changes in the international arena.

6.1.4 Crisis risks

Crisis risks happen when least expected, or very suddenly, for example heavy storms and natural disasters. As with other risks, they push households into financial crisis. Wright argues that they occur as a result of lack of proper planning of the two risks that have been identified earlier. When they happen, other households may decide to sell their belongings to deal with these emergencies. However, they need short-term intervention strategies. When the present study took place, there were severe storms and heavy rainfall in Qwaqwa and Harrismith. People lost their animals and their houses were destroyed. One wonders how they managed under those circumstances. Clearly this shows the need for Disaster Management policies for the country.

6.2 Unemployment

In a state of high unemployment, and the growth of the informal sector, it is highly unlikely that people will accept the idea of insurance. Most informally employed people have erratic income. A regular anticipated monthly contribution to insurance is almost impossible. In these circumstances, how will the day-to-day functions of the scheme be carried out? How will the scheme be sustainable in both the short – medium and long – term? Even if millions of Rands are pledged to kick-start the scheme, such a scheme will not be sustainable because of unemployment. Furthermore, regular income that is derived from employment can be used as an indicator of people's ability to contribute to a Community Based Health Insurance Scheme. However, unreliable and irregular income is a recipe for the financial instability of the scheme. Insurance as a concept requires people to make regular contributions to the scheme, in return for health care services. The results presented in the previous chapter indicate clearly that the income of these people is too little to be channelled to cover medical costs on a pre-payment basis. As long as their income is not improved through formal employment activities, it is not easy to encourage any methods of health insurance for them. Some of them have indicated that the do not even have the money to go to the nearest hospital, even though they can receive free care. On

the contrary, why should poorer people be encouraged to belong to a health insurance system when health services are available to them at no cost at all, as Chapter 5 revealed? Micro Finance Institutions and donors may find it difficult to convince poorer people to join the scheme under such circumstances.

6.3 Education

The results showed that almost 21% had no formal education. Many had secondary education. One wonders how easy it would be to explain the principle governing the insurance industry and the mechanism to which they should apply to bring down the cost of care. Literacy plays an important role in the insurance industry and illiteracy might be a risk when building insurance schemes. However, on the other hand, it can be seen from the results that there are a number of people in the survey that might have a better chance of being absorbed by the labour market and understanding the insurance principles. This applies to those with Standard 8 and Standard 10, because of their ability to read and write.

Kamdar (2002) argues that the changing nature of the economy will increase the demand for new skills in the working place. He says that there will be a great need for retraining and enhancing the current skills base (Kamdar, 2002:61). If the market continues at a snail's pace to absorb these people then their qualifications will be 'outdated', thus limiting their chances of getting jobs. The insurance concept is not easy to grasp. If people have low levels of education they will tend to increase the costs of care by abusing the system. However, even the affluent have a tendency to over-utilize their medical aid.

6.4 Pensions

Very interestingly, some households had pensions, which are reliable and of known size. The question arises: could this be used as collateral or as a backup for insurance, even though not all households receive it? It has been payable to women from the age of 60 and men from the age of 65 (Ardington and Lund,

1995: 557). Furthermore, Case and Deaton stated that its non-contributory nature and its ability to reach a number of people distinguish it from pension systems in developing countries (Case and Deaton, 1998: 1331 cited in Charlton and McKinnon, 2001: 182). Statistics show that old-age pensions reach about 75-80% of the age-eligible population (van der Berg, 1998: 6).

According to the Taylor Report, the State Old Age Pension (SOAP) appears to be the main social assistance programme, as it is distributed to about 1,9 million beneficiaries (Taylor Report, 2002). There is evidence of the impact of the SOAP on poor households and the role of the elderly in development (see Moller and Sotshongaye, 1996). In rural communities, pension income rotates or spreads widely and is vital in attacking poverty and reducing material insecurities.

van der Berg (1998) stresses that the pension should be seen as a powerful social programme tool for its effectiveness in targeting and reaching the economically vulnerable groups. A recent participatory poverty assessment concluded that 'without pensions, many households and communities would collapse' (May, 1996: 95 cited in Haddad and Zeller, 1997: 143). Lund (1993) contends that pensions are generally reliable and a regular source of income and are utilised by up to three generations within one household. Ardington and Lund further suggest that pensions can serve as a security for households to access credit. There is evidence of the use of pensions as support for the development of a micro-enterprise (Ardington and Lund, 1995: 572). Case points out that pensions can play a vital role in improving health (Case, 2001: 1-24). If pensions can be used for the development of micro enterprise and to improve health, as Ardington and Lund, together with Case suggest, would it be possible to target pensioners for the development of a Community Based Health Insurance Scheme? One cannot "say" yes because pensioners are faced with a number of health risks and this might affect the financial sustainability of the schemes. It should be made clear that the bulk of the pensioners' money goes to groceries and sometimes school-related activities. Therefore, channelling their pensions to

cover health might be blurred, considering that they receive free medical care at the point of service in the public hospitals. Building a sustainable health insurance scheme when the population is aging might prove fatal for most Community Based Health Insurance Schemes. Health insurance schemes are about income and health cross-subsidizations. Therefore the young and the healthy would find it very difficult to cross-subsidize the sick and the elderly. Young, affluent people have lost the sense of helping out those who cannot afford to live in an era of high unemployment and the emergence of chronic diseases. Perhaps the call for 'moral regeneration' might change the mindset of a young and healthy population, to actually pay for the health care of those who cannot afford it.

6.5 Health fears

People's perception about HIV/AIDS and disease patterns will be a huge risk to Community Based Health Insurance Schemes. People talked about health fears because they could see that they were vulnerable to health problems. Ideally, a package that includes coverage of HIV/AIDS, TB and the other most important diseases identified by these people would create a demand for the package. However, it would also contribute much to the un-sustainability of the scheme because of high drug costs and the higher number of people infected. The reasons for fear might differ. Those who are in their late twenties and early thirties wish to get married and have children, but fear that their partners are already infected. Lund and van der Ruit say that in the AIDS era, more family money will be channelled to buy health services.

The conditions in which the schemes should be set up need careful consideration. It would be very difficult to build a sustainable Micro Health Insurance Scheme in the context of the high prevalence of HIV/AIDS. It is clear that if an NGO wants to set up a health insurance scheme, it must take AIDS seriously and design a package that will cover the costs AIDS drugs. With the high levels of AIDS in South Africa, it appears that most people will join the

scheme because of fear of the disease. Some of them will join because they know that they are infected and thus increase the costs of care and affect the financial viability of the scheme. The government has been taken to court to provide "Nevirapine" drugs to avoid mother-to-child-transmission. It is estimated that between 25% and 35% of children born to mothers with HIV are infected (Adler and Qulo, 1999: 308). If anti-retroviral drugs are available in public hospitals, then the impact of dealing with the disease might not be enormous. This is because the State will buy the anti-retroviral at State tender prices that may translate into lower drug costs.

6.6 Use of different health services

It is important to include patients' views in policy-making. Most writers insist that it is vital to understand people's perceptions of quality of care in developing mechanisms that will encourage and increase the utilization of health services and that opinions concerning health services should be an integral part of quality evaluations (Baltussen *et al.*, 2002:42, Schneider and Palmer, 2002: 32). Considering these opinions, as presented in Chapter 5, a striking feature is that the quality of service of traditional healers is seen as much better than that provided in government health facilities. In this case, CBHIS could be designed to include traditional healers in their operations. If this is to be the case, government has to find ways and means to regulate the traditional healer industry, to comply and adhere to health standards in terms of medication and treatment. This brings the question of how to integrate informal mechanisms of social protection with the formal ones. People feel satisfied with the GPs' services, but there is a room for improvement, especially concerning the cost structure of the services provided by GPs. The main problem identified by respondents is that GPs are expensive. This has become a countrywide problem, as government and industry players are also trying hard to implement cost containment mechanisms in the private health care sector through the creation of low-cost options schemes. My considered view is that further research is needed in this area.

From the results, it is clear that government facilities are of poor standard in terms of quality of care, attitude and behaviour of health personnel and other various concerns that are prevalent in the public health facilities. It appears that quality is the major consideration to patients and may greatly influence the type of health institution they prefer. Furthermore, the quality of health services may be related to the cost of providing such services. It may be difficult to convince potential clients of MHI to contribute to a scheme when the cost of the health service is not related to the quality of the health service.

6.6.1 Access and use of health service

The adequacy of health services in Qwaqwa is minimal. Where it is available, people are unable to access it because of financial constraints. If an NGO wants to introduce insurance schemes it should first examine the kind of health institutions in the vicinity of the community and whether it will be easy for communities to access those health services. The introduction of health insurance in a state of limited health facilities is not going to benefit communities at all. Health facilities should be made available at community level if Community Based Health Insurance is to be considered. Health services are not adequate if people are unable to access them, so there is a need to ensure that the pricing of these services is affordable.

6.6.2 Factors influencing choice of health facility

The results suggest that people will only use the health institution when there are visible improvements. Quality of care is the major prerequisite for the use of health institutions (Newbrander and Collins, 2001:33). There is a serious concern about the quality of services offered in public hospitals. Stories have been heard of people sleeping on the floor in some of the public hospitals. Even though there is free health care for certain exempted individuals, people are unable to get medication and some are being told to use vinegar for flu.

The attitude and behaviour of health personnel should be improved. The public has a feeling that nurses are treating them badly and without respect. However, after hours the same nurse treats private patients with respect and dignity. Newbrander and Collins (2001) point out that poor quality care has individual and social costs implications. They say that the high levels of morbidity and mortality as a result of poor quality care may lead to higher social costs, such as loss of productivity. If MHI is aimed at insuring people against the risk of ill health and ensuring that they become productive in the enterprise, poor quality of care may undermine this goal.

The South African Health Review (2001) indicated that public health workers, policy-makers and politicians are showing an increasing commitment towards service delivery. The Review says that health workers, in particular facility managers, are the most frustrated people. Their frustrations stem from high workload and low remuneration. No proper guidance is given on carrying out responsibilities and duties, inefficient systems are entrenched, workload demands are increasing without supporting resources and there is inadequate physical space and disturbing conditions of service. Improvement in working conditions should be addressed with immediate effect if health insurance is to be used via the public hospital system. Introducing health insurance without first addressing the problems in the public hospitals system will lead to a 'war'. People will not pay for benefits that are not defined or that of poor quality. These issues should be dealt with at the national government and provincial government level to ensure that the budgets follow the policies of the national government. This will improve the co-ordination between programmes and support services. Furthermore, more interaction between the public and the private sector, rather that each sector blaming the other, could be a solution to solving some of these problems.

6.7 Savings

It appears that people are unable to save on a regular basis, because they are faced with interrelated risks that worsen their financial and health situations. If saving is an indicator of collateral status, then the people interviewed had no collateral or financial security. Health insurance will require that people contribute to the scheme on a regular basis. The fact that people are unable to save suggests that they might not settle for a pre-payment system of health care. The replies about savings indicate clearly that people only save for things like school fees, clothes and groceries. Therefore health insurance might not be sustainable in a situation of inability to save. Insurance, in itself, is a saving mechanism and it appears that people will not save for health, knowing that they can only access the benefits when they are sick.

6.8 Potential for Micro Health Insurance Scheme

It appears that there is very little potential for the development of a Micro Health Insurance Scheme, given the extent of poverty and inequality in South Africa, coupled with the emergence of chronic diseases. Poorer people may not contribute to a Micro Health Insurance Scheme when they can access the health services for free, in clinics and public hospitals. Then the question becomes: If people cannot have access to health, who should provide for them and how? And what are the consequences of non-provision? The consequences of non-provision will be very serious, as they may affect a whole range of issues, including child mortality rate, and Infant Mortality Rate. Therefore, will it be fair to say that the ultimate performance of the health care sector should be the responsibility of the government? Should it rather be said that those who can afford to pay for their health should do so or pay for the health of the unemployed? Answers to the questions are complex as they have social, economic and financial implications. What can be seen is that insurance might not be the only answer to finance health. Insurance as a concept requires people to contribute to the reserve, to enjoy the benefits. Given the growth of the

informal sector and high levels of unemployment, these thoughts might seem to be far-fetched. The policy recommendations that are suggested here have advantages and disadvantages. Some of these recommendations might not even be considered in the context of socio-economic and political environment of the country. However, they can be seen as being worthy of serious meditation.

6.9 Array of policy choices

In view of the findings of the present study and its implications, there are other alternative options that could be considered for financing and providing health care to poorer people. These are suggested below.

6.9.1 Basic Income Grant

The Taylor Report (2002) recommended the introduction of a Basic Income Grant as a mechanism to reach the poorest section of the population and to reduce poverty. Unlike the old age pension, this will be an entitlement that would be given without means testing. According to the Report, "such an entitlement supports the right to appropriate social assistance as entrenched in the South African Constitution 27 (1)(c) while furthering the vision of a comprehensive social security system as identified in the White Paper for Social Welfare" (Taylor Report, 2002:63). The ruling of the Constitutional Court with regard to the roll-out of Nevirapine drugs indicates clearly that socio-economic rights in the Constitution can be enforced. However, even though this can lead to equity, the capacity to implement such a grant might be a challenge. If implemented, the people of Qwaqwa could gain from this, more especially if the grant is given to everyone, because they live in larger households. In this regard, it could be a requirement that Community Based Health Insurance Schemes are built on the idea of insuring households rather than individuals and this could be compulsory and not voluntary. This means that virtually every household will have a form of health insurance. This will increase the risk pool and the size of the scheme, which will lead to more cross-subsidy of the sick by the healthy, and of the poorer by the richer.

6.9.2 Removal of Value Added Tax (VAT) on food

The removal of VAT on food has been advocated as a way of decreasing the burden of food prices on poorer people. However, Chen, Jhabvala and Lund (2002: 25) warn that VAT mostly affects informal workers, because they are both consumers and workers. They point out that the introduction of a flat value added tax rate could be a regressive step for informal workers, especially if it is applied on basic foodstuffs. Their argument is that low-income households spend more money on food than higher income households. For progressivity purposes, the strengthening and the allowance of zero-rating on specific basic commodities (e.g. paraffin) that are mostly used by poorer people requires urgent attention and commitment from the government. This will not deal entirely with the regressivity of VAT but will go a long way to curbing the problem (see Chen, Jhabvala and Lund, 2002: 25).

6.9.3 Diverting certain bank charges to a health fund

It has been shown that the transaction costs of banking are high for the poor and low-income earners, many of whom do not use the banking. Therefore, introducing a system where, say, every 0.1% of any withdrawal goes to a central health fund might prove to be progressive. What this means is that high-income earners will actually be paying for the health of the sick and the elderly. This too, might not be difficult to administer. However, it might cause chaos because high-income earners feel that the tax system is already burdening them. But it is also worthy of serious consideration.

6.9.4 Water and electricity accounts contributing to a health fund

This is another mechanism that could be used to help the poor in funding health. It is also progressive, in the sense that most people in rural areas have no electricity. It means that those in the metropolises and towns will subsidize those in the rural areas. In this case, like the banking idea, a certain percentage will be added to water and electricity accounts and that percentage will go to the central

health fund. In terms of administration and poverty outreach this could be feasible. However, there could be problems when the government electrification and water programmes reach their maximum. A way of not taxing the poor that gain access to water and electricity for the first time will have to be found.

6.9.5 Cutting the tax subsidy of the private sector

There is no doubt that the private health sector is contributing towards the inequities in the overall health sector. The Taylor Report recommended that this subsidy be restructured. According to the Taylor Report, the tax subsidy on medical aid contributions creates distortions in the health care market, as it artificially lowers the cost of private health care cover. In addition, it is highly regressive, as it provides a higher subsidy to high-income earners than to lower-income earners. The Taylor Report further go on to point out that this tax subsidy heightens the inequities between the public and private sectors, as it provides a higher per capita allocation to private medical scheme members than to public service users. Therefore, cutting down the R7.8 billion given to the private sector medical aid might also bear positive results for the public health care system that is mainly used by poorer people. The extent to which this tax subsidy should be restructured should be a joint undertaking between the Department of Health and the Treasury. However, employers should not be left out of the hook in these discussions.

6.10 Conclusion

In view of the presentation of the results of the survey, it is clear that the insurance route is not feasible in the short-to-medium-term, given the structural unemployment, low levels of education, chronic diseases, irregular incomes and declining quality of care. Even though it has become a necessity to deal with issues concerning social protection and risk management for the poorer people, Micro Health Insurance should not be seen as a panacea for addressing the needs of the poorest section of the population such as those in an area such as Qwaqwa. Micro Health Insurance is a highly technical undertaking; there are

several problems that may pose a threat for building a sustainable Micro Health Insurance Scheme. Micro Finance Institutions, which are seen as potential providers of Micro Insurance, are undeniably finding it very hard to offer effective and sustainable loans to poorer people. Adding Micro Health Insurance in those circumstances will undermine the goal of financial sustainability and this is important for any health insurance scheme. The consequences of non-provision may be detrimental to the entire marginalized population. Even though health care is not the only aspect of social security in South Africa, it plays a vital role in the productivity levels, which, in turn translates into economic benefits. The majority of the poorer people interviewed in this study are faced with a number of risks, including the fear of HIV/AIDS. The poverty and inequality and the lack of jobs is making it difficult for the poorer people to make ends meet. The impact of Micro Finance Institutions on poverty alleviation is questionable. It is further questionable whether Micro Finance Institution should be encouraging the addition of Micro Health Insurance as a new product in their portfolio to insure against ill-health or loss of income and assets. It appears that profit is the key driver in moving in this direction. The 'twin' goals of financial sustainability and poverty outreach may be difficult to achieve. Meeting the goal of financial sustainability may mean that a lot of poorer people will be excluded from such initiatives. At the same time, reaching the poorer people may imply long-term subsidization, from the donor point of view. Community Based Health Insurance, as advocated by international agencies, is not the answer to tackle the problems of ill-health and the emergence of new diseases in an area such as Qwaqwa.

The results of the study show that Community Based Health Insurance Schemes might not be sustainable, because of the complexities of the problems encountered by poorer people. In an area like Qwaqwa, Community Based Health Insurance Schemes may not be successful, for a number of reasons. Firstly, the people have irregular incomes, which will make monthly contributions very difficult, if not virtually impossible. Secondly, even though many had secondary education, the levels of education were generally low and this might

be a barrier to understanding the concept of insurance. Thirdly, people's perceptions' and fears concerning the emergence of chronic diseases such as HIV/AIDS are a huge risk for insurance schemes. For example, people will join the scheme knowing fully well that they are already infected with HIV/AIDS. The impact of HIV/AIDS will be huge if not properly assessed in the design of the scheme.

Fourthly, the extension of free health care in the public system, particularly for poorer people, makes it a serious competitor to the development of any Micro Health Insurance Scheme and future low cost options scheme in the health care industry. Lastly, the inadequacy of health service and the dissatisfaction with the public system in terms of attitude, behaviour and poor quality are an obstacle to building a low cost medical scheme in Qwaqwa. There is much that Micro Finance Institutions need to learn before they can offer such Micro Health Insurance products and to reduce the risk and vulnerability of the poorer people.

Micro Finance Institutions could perhaps explore the possibility of linking Micro Health Insurance products that are an informal form of social protection, to Social Health Insurance that is a formal form of social protection, if implemented correctly. Furthermore, the present study has recommended mechanisms that can be considered to contribute towards the health of the poorer people. The options are not exhaustive, but require careful consideration, in the light of increasing risk and vulnerability. The study indicates two clear areas for further research.

First, Chen and Morduch (2000) suggest that the creation of a hybrid of informal and formal mechanisms for social protection should be explored. The South African government is contemplating the development of a Social Health Insurance system and a Compulsory Medical Scheme for Public Employees. It is in this context that further research should be carried out to explore the possibility of linking Micro Health Insurance with Social Health Insurance. This may help in

achieving universal health coverage, as more people will be part of the contributory environment, except the indigent who may be subsidized from general taxation and a cross-subsidy environment. However, government should be cautious of creating a multiplicity of low cost schemes but should explore the possibility of opening up the Public Service Medical Scheme to groups outside the public service.

Second, the majority of people seem to be satisfied with the services provided by GPs, even though costs are high. The next step in research should be to consult the GPs to find ways of designing services that would possibly lower the costs to individuals, if they contracted in a group. If so, then the introduction of a Micro Health Insurance Scheme could become a reality, as people will pay low premiums, without GPs compromising the quality of care. This research should also explore alternative reimbursement mechanisms other than fee-for-service, which is entrenched in the health system.

Finally, then, the study demonstrated the difficulty of designing and implementing Community Based Health Insurance Schemes for poorer people and suggests that such insurance schemes should not be seen as an easy panacea, or an alternative to continuing State support.

References

Abel-Smith, B. 1986. 'Funding health for all – is insurance an answer?' **World Health Forum**, 7: 3-11.

Adler, G., and Qulo, O. 1999. 'HIV/AIDS and STDs', Chapter 22 in Health Systems Trust: **South African Health Review 1999**. Durban: Health Systems Trust.

ANC. 1994. 'A National Health Plan for South Africa', Johannesburg: ANC.

Ardington, E., and Lund, F. 1997. 'Questioning Rural Livelihoods', in Lipton, M, Ellis F and M Lipton (eds): **Land, Labour and Livelihoods in Rural South Africa Volume 2**. KwaZulu-Natal and Northern Province: Indicator Press.

Ardington, E., and Lund, F. 1995. 'Pensions and development: social security as complementary to programmes of reconstruction and development', **Development Southern Africa,** 12 (4): 557-577.

Atim, Chris 1998. 'The Contribution of Mutual Health Organization to finance, delivery, and access to health Care', Synthesis of Research in Nine West and Central African Countries: Abt Associates, Inc.

Atim, Chris. 1999. 'Social movements and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon', **Social Science & Medicine** 48 (1999): 881- 896.

Balnaves, M., and Caputi, P. 2001. '**Introduction to Quantitative Research Methods: An investigative approach',** USA: Sage Publications.

Baltussen, RMPM, Ye, Y., Haddad, S., and Sauerborn, RS. 2002. 'Perceived quality of care of primary health care services in Burkina Faso', **Health Policy and Planning**, 2002, **17**(1) 42 – 48.

Bramford, L. 1999. 'Tuberculosis', Chapter 23 in Health Systems Trust: **South African Health Review** 1999. Durban: Health Systems Trust.

Barron, P. and Sankar, U. 2000. 'Developments towards a district health system', Chapter 10 in Health Systems Trust: **South African Health Review 2000**. Durban: Health Systems Trust.

Bateson, N. 1984. **'Data Construction in Social Surveys**.' London: George Allen & Unwin Publishers Ltd.

Bennett, S. and Gilson, L. 2001. **'Health financing: designing and implementing pro-poor policies**.' London: DFID Health Systems Resource Centre.

Bernstein, H. 1992. 'Poverty and the Poor, Rural Livelihoods', Crisis and Responses. Oxford: Oxford University Press.

Bickelhaupt, David C. 1983. **'General Insurance.'** Illinois: Richard D. Irwin, (INC).

Bradshaw, D., Masiteng, K. and Nannan, N. 2000. 'Health Status and Determinants', Chapter 4 in Health Systems Trust: **South African Health Review 2000**. Durban: Health Systems Trust.

Brown, W., and Churchill, C. 1999. 'Providing Insurance to Low Income Communities Part I', A Primer on Insurance Principles and Products. Bethesda: Microenterprise Best Practices. (http://www.mip.org/pubd/mbp-def.htm)

Brown, W., and Churchill, C. 2000. 'Insurance Provision in Low Income Communities', Part *II* – Initial Lessons Learned from Micro-Insurance Experiments for the Poor. Bethesda: Microenterprise Best Practices. (http://www.mip.org/pubd/mbp-def.htm)

Brown, W., Green, C., and Lindquist, G. 2000. 'A Cautionary Note for Microfinance Institutions and Donors Considering Developing Microinsurance Products'. Bethesda: Microenterprise Best Practices Project.

Budlender, D. 2000. 'Human Development', in May, J. (ed.) 2000, **Poverty and Inequality in South Africa: Meeting the Challenge**. Cape Town and London: David Phillip and Zed Press.

Bynner, J. and Stribley, KM. 1979. **'Social Research: principles and procedures'**. London: Open University Press.

Carrin, G., De Graeve, D., and Deville, L. 1999. 'Introduction to Special Issues on the Economics of Health Insurance in Low and Middle-income Countries, **Social Science and Medicine** 48 (1999): 859-864.

Case, A., and Deaton, A. 1998. 'Large cash transfers to the elderly in South Africa, ' **The Economic Journal,** 108: 557 – 577.

Case, A. 2001. 'Health, income and economic development', Monograph prepared for the ABCDE Conference: World Bank.

Central Statistical Service 1997. 'Earning and Spending in South Africa', Selected findings of the 1995 Income and Expenditure Survey. Pretoria.

Charlton, R. and McKinnon, R. 2001. **'Pensions *in* Development.'** England: Ashgate Publishing Limited.

Chen, M. and Morduch, J. 2000. 'Roundtable on Micro Insurance Services in the Informal Economy.' The role of Micro-Finance Institutions hosted by International Coalition on Women and Credit and Special Unit for Micro finance of UNCDF. New York: The Ford Foundation.

Chen, M.A., Jhabvala, R., and Lund, F. 2002. 'Supporting Workers in the Informal Economy', A Policy Framework. Working Paper on the Informal Economy. Geneva: ILO.

Costa, J. (2002). 'Social Health Insurance in the Balkans.' London: DFID Health Systems Resource Centre.

Crehan, K. 1992. 'Rural Households: Making a Living, Rural Livelihoods: Crisis and Responses. Oxford, pp. 87-112: Oxford University Press.

Davies, S. 1996. 'Chapter 2, Adaptable Livelihoods', Coping with Food Insecurity in the Malian Sahel. London: MacMillan Press.

Department of Health Annual Report 2000/1. Pretoria.

Doherty, J., McIntyre, D. and Gilson, L. 2000. 'Social Health Insurance', Chapter 7 in Health Systems Trust: **South African Health Review 2000**. Durban: Health Systems Trust.

Dorfman, Mark S. 1978. **'Introduction to Insurance.'** New Jersey: Prentice-Hall Inc.

Dror, David M., and Christian Jacquier 1999. 'Micro- Insurance', Extending Health Insurance to the Excluded. UK: Blackwell Publishers and Oxford.

Edwards-Miller, J. 1998.' Measuring quality of care in South African Clinics and Hospitals' Chapter 14 in Health Systems Trust: **South African Health Review 1998**. Durban: Health Systems Trust.

Ensor, T. (2002.' Health insurance in Asia: issues from four countries.' London: DFID Health Systems Resource Centre.

FinaSol (2000). 'The Financial Services Co-operatives Programme,' FinaSol Report.

Free State Provincial Government 1999. 'Poverty Eradication Strategy for the Free State.' South Africa.

Gilson L, Doherty J, McIntyre D, Thomas S, Brijlal V, Bowa C, Mbatsha S 1999. 'The dynamics of policy change,' Health care financing in South Africa, 1994 – 1999. Johannesburg: Centre for Health Policy and Health Economics Unit.

Government Notice (1998). 'Exemption to the Banks Act,' Government Gazzette 393 (18741).

Haddad, L. and Zeller, M. 1997. 'Can social security programmes do more with less? General issues and the challenges for Southern Africa', **Development Southern Africa,** 14 (2).

Health Sector Strategic Framework 1994 – 2004. Department of Health.

Hirschowitz, R., and Orkin M. 1998. 'When you are hungry you can forget about health', a national household survey of health inequalities. Johannesburg: Community Agency for Social Enquiry (CASE).

Hock, C. 1996. '**The South African Microfinance Industry'. The state of play, the potential and pitfalls**. SARB seminar on Informal Finance.

Holzmann, R. and Jorgensen, S. 2000. 'Social Protection Discussion Paper Series, No. 0006 ', Social Protection. Washington, D.C.: World Bank.

Hulme, D. and Mosley, P. 1996. **'Finance Against Poverty'.** Vol 1. London: Routledge.

HSRC 2002. 'Nelson Mandela/HSRC Study of HIV/AIDS Household Survey 2002.' http://www.hsrcpublishers.co.za/hiv.html.

Kamdar, M. 2002. 'Reforming State-Owned Enterprises in South Africa'. **South African Journal of Social and Economic Policy**, Issue No. 6. 2nd Quarter, Pp 50 -66. Cape Town: Institute for African Alternatives.

Khosa, S. and Thomas, E. 1995. 'Free Health Care Policy', Chapter 14 in Health Systems Trust: **South African Health Review 1995**. Durban: Health Systems Trust.

McCoy, D., and Khosa, S. 1995. 'Free health care policies', Chapter 14 in Health Systems Trust: **South African Health Review 1996.** Durban: Health Systems Trust.

Kiwara, AD. 1999. 'Health insurance for the informal sector in the United Republic of Tanzania', in van Ginneken, W. (ed.): Social security for the excluded majority. Geneva: International Labour Office.

Krauss A. 1997. 'SEWA's Integrated Social Security Scheme', in Annette Krauss and Karl Osner 1997: Case Study on Empowerment, The SEWA-Approach, German Commission Justice and Peace. Working Paper Series 80e, Development has got a FACE, Volume 7:Bonn.

Kutzin, J. 1996. 'Health Insurance for the Formal Sector in Africa,' Yes, But... Chapter 5 in Sustainable Health Care Financing from EDI Health Policy Seminar Held in Johannesburg. South Africa: World Health Organization. http://www.worldbank.org/healthreform/library/sa/shaw5.pdf

Lipton, M., and Ravallion, M.1997. 'Poverty and Policy', in Behrman, J. and T.N. Srinivasan: **Handbook of Development Economics**, Vol 3, Amsterdam, pp: 2553-2583.

Lund, F. and Srinivas, S. 2000. **'Learning from experience, a gendered approach to social protection for workers in the informal economy**.' Geneva: ILO.

Matin, I., Hulme, D., and Rutherford, S. 1999.' Financial Services for the Poor and Poorest,' Deepening Understanding to Improve Provision. **Journal of International Development.**

May, J. (ed). 1998. **'Poverty and Inequality Report'.** Durban: Praxis Publishing.

May, J. 2000. **'Poverty and Inequality in South Africa: Meeting the Challenge**.' Cape Town and London: David Phillip and Zed Press.

Mayoux, L. 2001. 'Tackling the downside: social capital, women's empowerment and micro-finance in Cameroon', **Development and Change**, vol. 32.

Moller, V. and Sotshongaye, A. 1996. 'My family eat this money too: pension sharing and self respect among Zulu grandmothers', **Southern African Journal of Gerontology**, 5(2) pp. 9-19.

Morduch, J. 1999. 'The Microfinance Promise', **Journal of Economic Literature**, 37 (4): 1569-1614.

Morduch, J. 2000. 'The micro finance schism', **World Development** 28 (4): 617 – 29.

Moser, CA and Kalton, G. 1979. 'Question Wording,' in Bynner, J and Stribley, KM: **Social Research: principles and procedures**. London: Open University Press.

Mouton, J. and Marais, HC. 1990. '**Basic concepts in the methodology of the social sciences**.' Pretoria: Human Sciences Research Council.

National Department of Health. 'Uniform Patient Fee Schedule.' Pretoria. **http://www.doh.gov.za/programmes/upfs-f.html**

National Health Accounts Project 2000. '**The Public Sector Report.**' Pretoria: National Department of Health.

National Labour and Economic Development Institute. The compilation of the extent of poverty and inequality in South Africa. http://www.naledi.org.za/poverty.html

Newbrander, W., and Collins, D. 2001. 'Social Health Insurance Proposals in South Africa and the Implications for Public Hospitals.' Boston: Management Science for Health.

Normand, C. 1999. 'Using social Health Insurance to meet policy goals', **Social Science & Medicine** 48 (1999) 865-869.

Normand, C., and Weber, A. 1994. 'Social Health Insurance': A guidebook for planning. Geneva: WHO and ILO.

PSLSD 1994. 'Project for Statistics on Living Standards and Development,' South African Rich and Poor: Baseline Household Statistics. University of Cape Town: Southern Africa Labour and Development Research Unit.

Rahman H. Z. and Hossain M. 1995. 'Re-Thinking Rural Poverty a Case for Bangladesh,' Analysis of Poverty Trends Project. Dhaka: Bangladesh Institute of Development Studies.

Rakodi, C. 1995. 'Poverty Lines or Household Strategies,' A Review of Conceptual Issues in the Study of Urban Poverty. **Habitat International**, 19 (4): 407-426.

Report of the Commission on Macroeconomics and Health 2001. **'Macroeconomics and Health: Investing in Health for Economic Development.'** Geneva: WHO.

Report of the Committee of Inquiry into a Comprehensive Social Security for South Africa 2002. **'Transforming the Present – Protecting the Future.'** Pretoria.

Rhyne, E. 1998.'The Yin and Yang of micro finance,' reaching the poor and sustainability. Micro Banking Bulletin.

Ron, A., Abel-Smith B., and Tamburi, G. 1990. **'Health Insurance in Developing Countries, The Social Security Approach.'** Geneva: ILO.

Rossetti, A.G. (2002).'Social Health Insurance in Latin America.' London: DFID Health Systems Resource Centre.

Roussos, P and Ferrand, D. 1999. 'Review of the Micro-Finance Sector in South Africa.' Unpublished Report: Department of International Development.

Rutherford, S. 1998. 'The Savings for the Poor: Improving Financial Services in Bangladesh', **Journal of International Development,** 10 (1).

SADHS 1998. '**South African Demographic Survey.**' Pretoria.

SA-PPA 1998. 'The Experience and Perceptions of Poverty,' The South African Participatory Poverty Assessment. Durban: Data Research Africa Report.

Schneider, H., and Palmer, N. (2002). 'Getting to the truth? Researching user views of primary health care,' **Health Policy and Planning**, 17 (1): 32 – 41.
Schreiner, M. 1999. 'A cost effectiveness analysis of Grameen Bank of Bangladesh,' **Economic Development and Cultural Change**, 38 (1). Chicago: Chicago University Printers.

Shaw, P., and Griffin, C. 1995. 'Financing Health Care in Sub-Saharan Africa through User Fees and Insurance.' Washington: World Bank. http://www.worlbank/healthreform/library/sa/shaw11.pdf

Smith, HW 1975. '**Strategies of Social Research: The Methodological Imagination.**' New Jersey: Prentice-Hall, Inc.

Smith MJ, Cornell J, and Solanki G. 2001. '**A Study of Public Priorities, Willingness and Ability to Pay for Social Health Insurance in South Africa.**' Department of Health, Pretoria: Strategy and Tactics.

South African Stroke Foundation website:
http://www.stroke.co.za/About_S_A_S_F/body_about_s_a_s_f.htm

Social Health Insurance Scheme for South Africa 1997. 'Policy Document.' Pretoria: Department of Health.

Statistics South Africa website:
www.statssa.gov.za/Statistical releases/Statistical_releases.htm).

Strauss Commission 1996. **'Report of the Commission of Inquiry into the provision of Rural Financial Services.'** Pretoria.

The Constitution of the Republic of South Africa Act 108 of 1996.

Thomas, S., Muirhead, D., Doherty, J. and Muheki, C. 2000. 'Public Sector Financing,' Chapter 5 in Health Systems Trust: **South African Health Review 2000**. Durban: Health Systems Trust.

Thompson, C. (2002).' Social Health Insurance in sub-Saharan Africa.' London: DFID Health Systems Resource Centre.

Tickamyer, A. R., and Wood, T.A. 1998. 'Identifying participants in the informal economy using survey research methods.' **Rural Sociology**, 63 (2): 323-339.

World Bank 1990. 'Chapter One: Poverty Lines, Profiles and Indicators', **Poverty Reduction Handbook**. Washington, pp 13 – 29: World Bank.

World Bank Group 1996. 'World Development Report 1996,' **From Plan to Market**. New York: Oxford University Press.

Wright, Graham A.N. 1999. 'Necessity as the Mother of Invention,' How Poor People Insure Against Risk. Kampala: MicroSave-Africa. Mimeograph.

van der Berg, S. 1998. 'Ageing, public finance and social security in South Africa,' **Southern African Journal of Gerontology**, 7(1): 3 –9.

van der Ruit, C. and Lund, F. 2001. 'Credit or Debt? The impact of micro-credit on survivalist workers in the informal economy.' Unpublished working paper. Durban: School of Development Studies. Part 1.

van Ginneken, W. 1999. 'Overcoming social exclusion', Chapter 1 in van Ginneken, W. (ed.): Social security for the excluded majority. Geneva: International Labour Office.

van Rensburg, H C J., Fourie, A., and Pretorius, E. 1992. '**Health Care in South Africa: Structure and Dynamics.**' Pretoria: Academica.

Visser, C. 1993. 'AIDS and Insurance Law: A Preliminary Laundry List of Issues,' **South African Journal on Human Rights**, 9(1). Cape Town: JUTA & CO, LTD.

Zigora, T.A. 2000. 'Current Issues, Prospects, and Programs in Health Insurance in Zimbabwe,' Chapter 11 in Sustainable Health Care Financing from EDI Health Policy Seminar Held in Johannesburg. South Africa: World Health Organization.

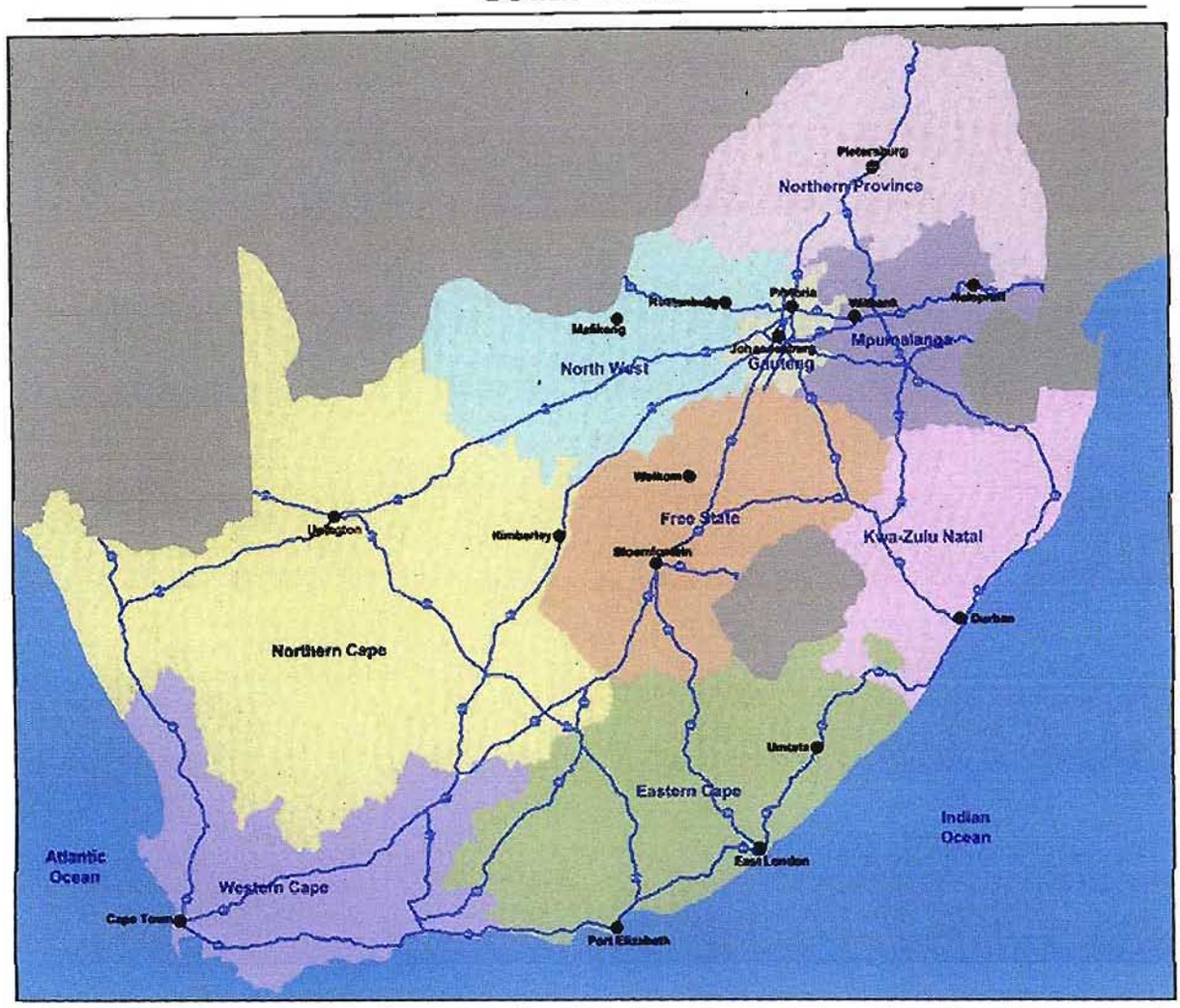
ANNEXURE

APPENDIX 1

The gayteway to South Africa

South Africa
W Cape | E Cape | N Cape | Kwa-Zulu Natal | Mpumalanga | Free State | North West | Northern Province | Gauteng

South Africa



home | news | entertainment | travel | bars/clubs | community | Queer Maps | chat | email | links

Q editorial | Q marketing | Q webmaster

Phone number: 27-11-727-7000

APPENDIX 2

Thabo Rakoloti
University of Natal
School of Development Studies
Durban
4041
05 September 2001

ACDI/VOCA South Africa
FinaSol
PO Box 61
Kloof
3640

Dear Mr Thomas K. Shaw

Re: Research work with FSC's in Qwaqwa

I am currently studying a Masters degree in Development Studies at the University of Natal. The main requirement for the completion of the degree is to write a dissertation on the topic related to the broader developmental issues. My research is based on the provision of health insurance for people in the informal sector.

I have noticed and read that poor people are exposed and vulnerable to financial risk of illness or deaths, which cause losses that, are beyond their control. One can simply say that poor people are not shielded against these risks. The situation is compounded by the fact that traditional insurers are reluctant to serve the poor households because the product has high transaction costs and the difficulty in controlling moral hazard and adverse selection. The growing body of evidence points out that the provision of health insurance can help in reducing the vulnerability and the impact of household losses that could worsen their poverty circumstance.

I would therefore, appreciate if FinaSol can allow me to conduct a research with its clients whom I see as relevant to this kind of research. I am hoping to do at least 30 –35 interviews (3 –4 interviews a day) for a period of two weeks, starting from the 10/09/2001 until 21/09/2001.

Hoping and trusting that my request will be highly appreciated.

Yours Sincerely

Thabo Rakoloti.

Section 1: HOUSEHOLD COMPOSITION

Name	Relationship To household	Age	Sex	Education	Occupation	Income contributed monthly

Section: 2

2.2.1 If you are **formally employed,** how do you pay for your medical costs?

- Pay by cash
- Pay by cheque
- Medical Aid
- Other (Specify)_____

Have you ever requested your employer to pay your medical costs by alternative means? Y / N_____

If YES, what means was requested and why? _____

_____

_____

_____

_____

2.2.2 If you are **Self-employed,** in what type of business are you engaged? (Tick the relevant box).

Farming (Specify crop)_____	Contracting	Hawking	Other (Specify) _____

What is the most frequent method by which you pay for your medical costs?

- Cash
- Cheque
- Medical Aid
- Other (Specify)_____

2.2.3 If you are a **pensioner**, how do you pay for your medical costs?

- Cash
- Credit
- Medical Aid
- Electronic payment
- Other (Specify)_____

2.2.4 Are you aware that you can cover your medical costs through a **Health Insurance Scheme?** Y /N_____

2.2.5 If YES, why do you not use the service? _____

_____

2.2.6 If NO, would you consider using the service? Y / N ____ If NO, why? _____

_____

Section 3: Health Care Utilization and Access to Health

Complete the following table on Health services in your region.

Health Care Provider	**Frequency used**	**Location**	**Service**	**Costs**	
Traditional Healers	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	
Private Doctor	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	
Hospital Emergency	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	
Clinics	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	

3.1 What do you think about how they compare?

Notes
Now I am going to ask you about how different health services compare- for how often you use, distance, quality, service and costs.
Here I'll be using cards and do a ranking game where the subject is going to rank these in comparison to each other.
Frequency visited: 0= never, 1= more than once a year, 2= more than once every week, 3= every week.
Location: 0= don't know; 1= inconvenient (distance, usually have to make a special trip to visit)
2= reasonable (distance reasonable sometimes have to make special trip to visit it), 3= convenient (close proximity to house, work, etc...)
Service: What is the quality of service like? 0= don't know, 1= poor, 2= adequate, 3= good

Costs: Note costs to be assessed relative to other health service providers. 0= don't know, 1=very expensive, 2= expensive, 3= average, 4= cheap and 5= very cheap

3.2 On a scale of 1 to 5, (where 1 is strongly disagree, 3 is neither agree nor disagree and 5 is strongly agree), rate the following statement:

Adequate health services are available to people who live in this area	1 2 3 4 5

3.3 What are the 3 (THREE) most important factors in your choice of Health Institutions?

- _____
- _____
- _____

Section 4: Illness and Accidents

4.1 Has any member of your family been sick in the last 12 months? Y/ N_____
4.2 What was the cause of their illness? E.g. flu, headache, fever, accident etc
Please specify_____

4.3 What source of money was used to pay for the costs of this treatment? E.g. loan from family, loan from mashonisa, animal sales or from savings etc.
Specify_____
4.4 Where do you most often buy medications? E.g. village, hospital or chemist. Specify_____

Section 5: Pregnancies

5.1 Have any of the women in your family given birth in the last 12 months? Y/ N____
5.2 Where did the mother give birth? E.g. home, hospital etc_____
5.3 Who helped with the birth? E.g. doctor, nurses, mid-wife, don't know etc. Specify_____
5.4 How much did the family pay for the assistance with the birth? R_____
5.5 How did you pay for the costs? E.g. loan from family, loan from mashonisa or animal sales? _____
5.6 If she had the choice, where would the mother prefer to have given birth? E.g. home, hospital or clinic. Specify_____

Section 6: Deaths

6.1 Did you lose a member of your family for the past 12 months? Y/ N_____
6.2 How many? _____
6.3 How much did each funeral cost? R_____
6.4 How did you pay for the funeral expenses? E.g. loans from family, burial societies
Specify_____

Section 8: Management of family Expenditures

8.1.1 What are the three (3 health problems that you fear most? E.g. broken limbs, death, risky childbirth etc.
Specify_____
8.1.2 Which of these problems would have a lasting impact on your business? _____
8.1.3 If one of these problems affected a family member, what would you do? E.g. sell an asset; take out a loan, etc.
Specify_____
8.1.4 Other than health problems, are there other risks that causes your family financial difficulties? E.g. funeral cost, celebration costs, building a house etc. Indicate_____
8.1.5 What are the total costs of these events? R_____
What do you normally do to find the money to pay for these events? E.g. loan from mashonisa or animal sales etc.
Specify_____

Section 9: Stories about Savings

9.1 Have you ever attempted to save money in the last three- (3) years? Y/ N_____

9.2 If yes, what for? _____

9.3 Did you succeed? Y/N_____

9.4 What is your secret of success?

_____

_____

_____

_____

_____

9.5 If you failed, what were the reasons?

_____

_____

_____

_____

_____

Section 10: Risks

10.1 Has anyone in the household faced one the following risks in the last 3 years? Circle all that applies.

- Losses of stock
- Loss of employment/job
- Burglary of household goods
- Fire
- Loss of pension
- Crop failure
- Disability

Other? Please specify_____

Annexure 4

Classification of Patients for the Determination of Fees

Introduction

This annexure is based on the decision of the PHRC of 21 July 2000 to adopt Option C presented in Annexure G.

Patients are classified into two main groups for the purposes of service fee determination:

Full Paying Patients. This category of patients includes, but is not limited to, externally funded patients, patients being treated by their private practitioner, and certain categories of non-South African citizens. They are liable for the full UPFS fee as listed in Annexure A. See Table 1 for full details of this category of patient.

Subsidised Patients. These are patients who do not fall in the category of full paying patients. Subsidised patients are categorised further based on their ability to pay for health services into three categories: H1, H2 and H3. The fees payable by subsidised patients are expressed as a percentage of the fees payable by full paying patients as determined by the Uniform Patient Fee Schedule (UPFS) (Annexure A).

The classification of dependants is determined by the classification of their guardians.

Free Services. There exist circumstances under which patients will receive services free of charge independently of their classification as full paying or subsidised patients. These circumstances have a statutory basis and apply only to the episode of care directly related to the circumstances under which the patient has qualified for free services. Table 2 summarises the circumstances under which patients will qualify for free services.

Subsidised Patients

Subsidised patients are divided into two main groups:

Full subsidisation (H1). Patients in this group receive all services free of charge. Patients must provide proof in terms of the conditions set out in Table 3 in order to be classified into this group.

Partial subsidisation (H2 and H3). This is the default group for subsidised patients and the level of subsidisation depends on a means test. The income cut-off point between H2 and H3 patients is set at the 90th income percentile as determined by Statistics South Africa. This means that 90% of employed individuals earn less than the cut-off amount per annum. Currently this amount is a yearly income of R70 000 for a single person. Table 4 lists the subsidisation percentages for H2 and H3 for the services covered by the UPFS. Illustrative amounts for some common services are listed in Table 5.

ITT / 2007 / 7

Annexure 4

Full Paying Patients

Table 1: Full Paying Patients

Group	Description
Externally funded patients	1. Patients whose health services are funded or partly funded in terms of: (a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993), (b) the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act No 56 of 1996), (c) a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998). 2. Patients treated on the account of: (a) another state department, (b) local authority, (c) foreign government, (d) any other employer.
Patients treated by a private practitioner	Any patient treated by his or her own private practitioner in a public health care facility will be liable to pay the full facility fee component for services rendered by the private practitioner at the facility and the full UPFS fee for any other service received by the patient.
Non South African citizens	Non South African citizens excluding the following: (a) immigrants permanently resident in the RSA but who have not attained citizenship (b) non South African citizens with temporary residence or work permits (c) persons from neighbouring states (e.g. Mozambique, Zambia, etc) who enter the RSA illegally.

Free Services

Table 2: Free Services

Service	Basis
Free health services for pregnant Women and children under the age of 6 years	NOTICE 657 OF 1994, 1 July 1994 As from 1 June 1994, free health services must be provided to : a. pregnant women for the period commencing from the time the pregnancy is diagnosed to forty-two days after the pregnancy has terminated, or if a complication has developed as result of the pregnancy, until the patient has been cured or the conditions as result of the complication has stabilised; b. children under the age of six years; c. non-citizens of South Africa who are in the groups mentioned in par (a) and (b), and who incidentally develop a health problem whilst in South Africa. Free health services included the rendering of all available health services to the persons mentioned in above, including the rendering of free health services to pregnant women for conditions that are not related to the pregnancy. The following persons are excluded from the free health services: a. Persons and their dependents who are members of a medical scheme. b. Non-citizens of South Africa who visit South Africa specifically

	for the purpose of obtaining health care.
Free primary health care services	Notice 1514 of 1996, dated 17 October 1996 1. Primary health care services are available free of charge at State health care facilities. 2. Services referred to in paragraph 1 are available at- (a) State health care facilities, namely- (i) clinics; (ii) community health centres; (iii) mobile clinics; (iv) satellite clinics; (b) health care facilities that are funded or subsidised fully or partly by the State; (c) hospitals in geographical areas where facilities referred to in subparagraphs (a) and (b) are not available and which are designated by a province for that purpose. 3. Persons receiving primary health care services at facilities other than those referred to in paragraph 2 shall be liable to pay existing rates and an additional fee as determined by the province. 4. An additional fee referred to in paragraph 3 shall not be payable in the case of emergency care. 5. Only South African citizens shall be entitled to free primary health care services. 6. The following persons shall not be entitled to free primary health care services: (a) Persons and their dependents who are members of a medical aid scheme; (b) Persons who make use of the services of medical practitioners of their choice instead of those made available by the health care facility.
Termination of Pregnancy	Act 92 of 1996. Services in respect of the termination of pregnancy to be rendered free of charge and, if complications have developed as a result of the termination, until the patient has been cured or the conditions as a result of the complication have stabilised, under the following conditions:- 1. Upon request of a women during the first 12 weeks of pregnancy; 2. From the 13th to the 20th week of pregnancy if a medical practitioner, after consultation with the woman, is of the opinion that a. continued pregnancy poses a risk to the woman's physical or mental health b. a substantial risk exists that the foetus would suffer from a severe physical or mental abnormality c. the pregnancy resulted from rape or incest d. the continued pregnancy would significantly affect the social or economic circumstances of the woman 3. after the 20th week of pregnancy if a medical practitioner, after consultation with another medical practitioner or midwife, is of the opinion that continued pregnancy would a. endanger the woman's life b. result in severe malformation of the foetus c. would pose risk of injury to the foetus
Criminal Procedure Act	Act 51 of 1977 Services rendered in terms of the above act, as well as the following

	when requested by the responsible authorising body. Assault: The examination of the alleged victim and taking of samples and completion of the necessary documentation Rape: The examination of the alleged victim and taking of samples and completion of the necessary documentation Post mortem: The performance of autopsies and attendance at exhumations Corporal Punishment: Preliminary examination for the administration of corporal punishment by the Police Service and attendance at the administration at corporal punishment in prisons.
Child Care Act	Act No 74 of 1983, Section 15. Children who in terms of the above Act are committed to the care of a children's home, industrial school or foster parents.
Persons with mental disorders	Mental Health Act (Act 18 of 1973) The examination of prisoners and detainees for medico-legal purposes with a view to their referral for observation in terms of the Act. Mentally disturbed patients admitted to psychiatric hospitals in terms of section 9 of the Act.
Infectious, formidable and/or notifiable Diseases	1. Venereal diseases (excluding complications) - only on an outpatient basis and including the following: Syphilis, gonorrhoea, chancroid, LGV (lymphogranuloma venereum), non-specific urethritis, venereal warts, granuloma inguinale, ulcus molle, herpes genitalis. 2. Pulmonary tuberculoses. 3. Leprosy. 4. Cholera. 5. Diphtheria. 6. Plague. 7. Typhoid and paratyphoid. 8. Haemorrhagic fevers. 9. Meningococcal meningitis. 10. Aids - only the initial diagnostic procedures and attendant laboratory services are free if patients specifically ask for the HIV test to be done. Patients requiring treatment are assessed at the prescribed tariffs for any hospitalisation and accompanying services.
Other exempt conditions	Persons suffering from the following diseases for treatment only relating to such diseases: 1. Malnutrition 2. Pellagra 3. Any other condition or service as determined by a province
Donors	A donor is a person who, of their own free will, presents themselves specifically for the donation of an organ, blood, milk or human tissue. The exemption refers to services rendered in respect of the donation.

Annexure 4

Patients qualifying for full subsidisation : H1

Table 3: Patients qualifying for full subsidisation

Group	Description
Social pensioners	Recipients of the following types of pension/grants are classified as social pensioners: Old age pension Child support grant Veteran's pension Care dependency grant Pension for the blind Family allowance Maintenance grant Disability grant Single-care grant - Persons with mental disorders in need of care discharged from hospitals for the mentally ill, but have not been decertified. Should the social pensioners also belong to a medical scheme, they will be regarded as full paying patients.
Unemployed	Proof of unemployment must be produced. (Contributors Record Card (UF74)).
Persons re-classified as H1	If a patient cannot afford the fees due on the basis of his or her original classification then the patient may be re-classified as H1 by the person in charge of the health care facility on the basis of a social worker's report.

Patients qualifying for partial subsidisation (H2 &H3)

Table 4: Partial Subsidisation

Category	Means Test	Subsidisation (% of UPFS)
H2	Individual : Income less than R70 000 per annum Household : Income less than R100 000 per annum	Consultations : 70% Inpatient days: 6% Patient and Emergency Transport: 15% Assistive devices : 50% All other services : Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H3	Individual : Income greater or equal to R70 000 per annum Household : Income greater or equal to R100 000 per annum	All services listed in the UPFS at 70%

Annexure 4

Table 5: Illustrative Fees

Service	H2	H3
Consultations		
Routine, General Practitioner at Level 1&2 hospital	R65	R65
Emergency, General Practitioner at Level 1&2 hospital	R95	R95
Inpatient day		
General ward, GP at Level 1&2 hospital	R35	R415
High care ward, GP at Level 1&2 hospital (per 12hours)	R40	R475
Patient & Emergency Transport		
Patient Transport (per 100km)	R25	R105
Basic Life Support (per 50km)	R35	R170
Intermediate Life Support (per 50km)	R45	R210
Advanced Life Support (per 50km)	R60	R270