

3 Stakeholder Views

3.1 Overview

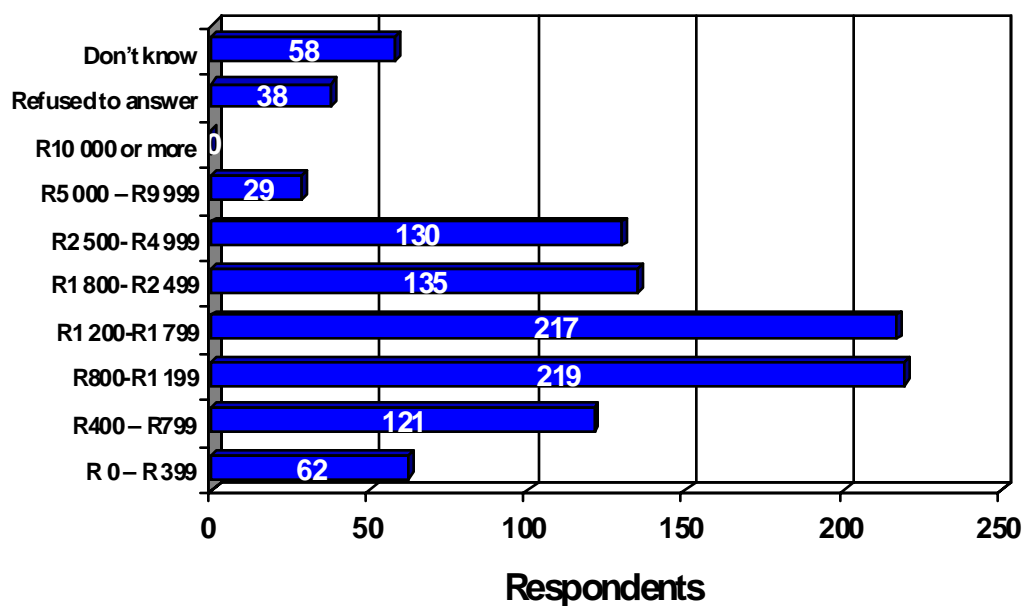
The views of a range of stakeholders were obtained on various aspects of the health system and possibility of some form of mandatory contribution for health cover. On the whole dissatisfaction was expressed on the current public health service. Many groups, including employers, supported the strengthening of the public sector, particularly access to hospital services, as important for the future. A willingness to contribute over-and-above existing contributions was expressed by many, but only on condition an improvement in the public service occurred first. Many supported the idea of some form of enhanced amenity within the public sector for contributors. There was however limited support for enhanced services offered on a differential basis.

3.2 Willingness to pay

Many groups are willing to pay a small fee (pre-paid) provided the public sector improves its services first. Opposition to payment of such a fee did not emanate from potential contributors, but rather from the national Treasury (blanket opposition to earmarked taxes) and certain (but not all) trade unions (near-poor should not cross-subsidise the very poor). The latter trade unions supported a universal earmarked tax provided they could choose to fund these services in the private sector. Other trade unions supported the idea of a contribution provided they received something in return. They were supportive of these services being in the public sector. Evidence of the functioning and benefits of a low cost contributory system is provided by the clothing workers.

A willingness and ability to pay survey (W&A study) conducted by the Department of Health sampled the views of around 1,000 individuals of varying incomes (**figure 3.1**) on various aspects of their willingness and ability to contribute to a social health insurance fund focusing on public hospital services.

Figure 3.1: Willingness and Ability to Pay Study – Distribution of Respondents by Income



Source: Department of Health, August 2001.

Over 94 percent of respondents in the W&A study felt it was appropriate to pay for public hospital services. Up to 45 percent felt that public hospital services would improve if there were some form of additional payment. Another 36 percent felt people should pay for what they use. (Table 3.1).

Table 3.1: Willingness and ability to pay study: Reason for willingness to pay for public hospital services

Reason	Resp	%
Public Hospitals provide value for money	40	4.7
I think people should pay for what they use	305	36.0
Services will improve at public hospitals if we all pay something	382	45.1
I believe in Masakhane (civic duty) so it is our duty to pay	77	9.1
You have to pay otherwise they send you a lawyers letter demanding payment.	14	1.7
Other (please specify)	30	3.5
Total	848	100.0

Source: Department of Health, August 2001.

3.3 Ability-to-pay

Interviewees and stakeholders were not able to give a clear comment on this issue as no contribution level was put to them. However, it was felt that if a pre-paid contributory system were created they would probably voluntarily pay if they had access to improved services.

The W&A study found that 77 percent of respondents were able to pay when last receiving care at a public hospital. Given that 61 percent of respondents come from the income groups R0-R2,000 per month, this indicates that a significant number of low-income groups are able to pay at least something toward their health care.

Table 3.2: Willingness and ability to pay study: Able-to-pay when last receiving care at a public hospital

Able To Pay	Resp	%
Yes	608	76.9
No	161	20.4
Cant Remember	22	2.8
Total	791	100.0

Source: Department of Health, August 2001.

The W&A study suggests that 73 percent of respondents are willing to use and pay for public hospitals.

Table 3.3: Willingness and ability to pay study: Willingness to use and pay for public hospital care

Opinion	Resp	%
Willing to use Public Hospital, not willing to pay	56	5.6
Not willing to use public hospitals	166	16.5
Willing to use Public Hospitals, willing to pay	732	72.6
Don't Know	55	5.5

Source: Department of Health, August 2001.

3.4 Earmarked tax

There were differences among government officials as to how they would understand an earmarked tax for health services. The national Treasury saw these as part of the general tax system, and therefore any earmarked tax will have to be off-set by a reduction of budget. Health

officials saw an earmarked tax as replacing some tax funding, but also providing new funding. The rationale for new funding arises from the following:

- (a) The willingness to make an additional contribution;
- (b) The recovery of funds that should have been raised from the point-of-service billing of existing users; and
- (c) The need for full-cost recovery for new users of the public system.

The W&A study found that a significant proportion of the population (90 percent) interviewed were willing to accept a compulsory system of public hospital cover if services were improved. (Table 3.4).

Table 3.4: Willingness and ability to pay study: Support for compulsory membership if Public Hospital Insurance

	No		Yes		Don't Know	
	Resp	%	Resp	%	Resp	%
Support if the public hospitals stay as they are	903	89.5	96	9.5	10	1.0
Support if public hospitals are improved	85	8.4	908	90.0	16	1.6
Support if scheme members get differential treatment	402	39.8	567	56.2	40	3.1

Source: Department of Health, August 2001.

If no services were improved only 9.51 percent were willing to contribute. The introduction of mandatory cover of any form must involve a discernable improvement in hospital services. The results are similar where a payroll deduction is proposed (table 3.5).

Table 3.5: Willingness and ability to pay study: Support for compulsory Payroll deduction for covering public hospital costs

	No		Yes		Don't Know	
	Resp	%	Resp	%	Resp	%
Support if the public hospitals stay as they are	878	87.0	110	10.9	21	2.1
Support if public hospitals are improved	104	10.3	874	86.6	31	3.1
Support if scheme members get differential treatment	418	41.4	533	52.8	58	5.8

Source: Department of Health, August 2001.

Overall 55.9 percent of respondents in the W&A study felt that members of medical schemes should be excluded from any mandatory payroll deduction versus 34.8 percent who thought they should. (Table 3.6).

Table 3.6: Willingness and ability to pay study: Support for payroll deduction with exemptions for Medical Aid members

	No		Yes		Don't Know	
	Resp	%	Resp	%	Resp	%
Support for payroll deduction with exemptions for Medical Aid members	351	34.8	564	55.9	94	9.3

Source: Department of Health, August 2001.

Funding of the Public Sector:

Apart from the national Treasury, there is a general consensus (employers, trade unions and workers) that the public sector is under-funded which encourages all who can pay to use private sector services.

Tiering (differential amenities or "buy-up options in public sector hospitals):

Although there was some variation in the responses from trade union members, there was a large degree of support for differential amenities. There was however no support for differential services. **Table 3.7** reports the responses on the W&A study toward differential amenities.

Table 3.7: Willingness and ability to pay study: Attitude towards a differentiated public health service

	Strongly Agree		Agree		Unsure		Disagree		Strongly Disagree	
	Resp	%	Resp	%	Resp	%	Resp	%	Resp	%
Payers should be treated First	185	18.3	204	20.2	47	4.7	422	41.8	151	15.0
Payers should get nicer Wards	163	16.2	287	28.4	40	4.0	424	42.0	95	9.4
Payers should be able to make appointments	1	0.1	218	21.6	365	36.2	53	5.3	296	29.3
Payers should have TV's in their rooms	133	13.2	316	31.3	102	10.1	369	36.6	89	8.8
Payers and non payers should get same care	358	35.5	294	29.1	109	10.8	162	16.1	86	8.5
Won't use public hospitals regardless of improvements	45	4.5	33	3.3	92	9.1	414	41.0	425	42.1

Source: Department of Health, August 2001.

3.5 Improvement of public sector services

Employers, union representatives and workers indicated that reasonable improvements in the public sector will probably result in their shifting away from expensive private cover. Some unions were adamant that improvements to the public system should precede any introduction of a contributory system. Key problems raised were:

- (a) Shortages of medicine;
- (b) Poor physical condition of facilities;
- (c) Facilities are not clean;
- (d) Poor service delivery;
- (e) Rude staff;
- (f) Lack of doctors at clinics; and
- (g) Insufficient staff.

3.6 Injection of funds

Quite a few respondents (including employers and trade unions) raised the issue of a one off injection of funds to provide a face-lift to public sector services to initiate a contributory system.

3.7 Phasing

There was universal support for a phased approach to implementation with an initial focus on creating a voluntary contributory environment. This could either be via a voluntary SHI or a low cost medical scheme. A few supported the idea that the process should begin with public sector employees.

3.8 Revenue retention at facility level

The inherent logic of revenue retention at the facility level was accepted by all groups including the national Treasury. However, there was uncertainty amongst other government officials concerning the true position of the Treasury Department.

3.9 Benefits

Employers felt that contributions and not benefits should be defined. Certain trade unions felt they should be allowed to opt for private primary care and a contribution toward public hospital service. Certain trade unions did not want any restriction on their choice of service provider.

3.10 Findings and Concluding Comments

There is an understandable variation in what different stakeholders understand by social health insurance. There nevertheless appears to be a fair degree of consistency in how stakeholders interpret their preferences in relation to a number of alternative options.

The following arise from the results:

- a) *Willingness to pay*: Many groups are willing to pay a small fee (pre-paid) provided the public sector improves its services first. Opposition to payment of such a fee did not emanate from potential contributors, but rather from the Treasury Department (blanket

- opposition to earmarked taxes) and certain (but not all) trade unions (near-poor should not cross-subsidise the very poor). The latter trade unions supported a universal earmarked tax provided they could choose to fund these services in the private sector. Other trade unions supported the idea of a contribution provided they received something in return. They were supportive of these service being in the public sector. Evidence of the functioning and benefits of a low cost contributory system is provided by the dothing workers.
- b) *Ability to pay*: Interviewees and stakeholders were not able to give a clear comment on this issue as no contribution level was put to them. However, it was felt that if a pre-paid contributory system were created they would probably voluntarily pay if they had access to improved services.
- c) *Earmarked tax*: There were differences among government officials as to how they would understand an earmarked tax for health services. The Treasury Department saw these as part of the general tax system, and therefore any earmarked tax will have to be off-set by a reduction of budget. Health officials saw an earmarked tax as replacing some tax funding, but also providing new funding. The rationale for new funding arises from the following:
- o The willingness to make an additional contribution;
 - o The recovery of funds that should have been raised from the point-of-service billing of existing users; and
 - o The need for full-cost recovery for new users of the public system.
- d) *Funding of the Public Sector*: Apart from the Treasury Department, there is a general consensus (employers, trade unions and workers) that the public sector is under-funded which encourages all who can pay to use private sector services.
- e) *Tiering*: Although there was some variation in the responses from trade union members, there was a large degree of support for differential amenities. There was however no support for differential services.
- f) *Improvement of public sector services*: Employers, unions representatives and workers indicated that reasonable improvements in the public sector will probably result in their shifting away from expensive private cover. Some unions were adamant that improvements to the public system should precede any introduction of a contributory system. The key problems raised were:

- Shortages of medicine;
 - Poor physical condition of facilities;
 - Facilities are not clean;
 - Poor service delivery;
 - Rude staff;
 - Lack of doctors at clinics;
 - Insufficient staff.
- g) *Injection of funds*: Quite a few respondents (including employers and trade unions) raised the issue of a one off injection of funds to provide a face-lift to public sector services to initiate a contributory system.
- h) *Phasing*: There was universal support for a phased approach to implementation with an initial focus on creating a voluntary contributory environment. This could either be via a voluntary SHI or a low cost medical scheme. A few supported the idea that the process should begin with public sector employees.
- i) *Revenue retention at facility*: The inherent logic of revenue retention at the facility level was accepted by all groups, including the Treasury Department. However, there was uncertainty amongst other government officials concerning the true position of the Treasury Department.
- j) *Benefits*: Employers felt that contributions and not benefits should be defined. Certain trade unions felt they should be allowed to opt for private primary care and a contribution toward public hospital service. Certain trade unions did not want any restriction on their choice of service provider.