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Final Draft

The Future Role of Medical Schemes in South Africa: A response to the White Paper on NHI

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Prepared for the Hospital Association of South Africa

Proposed Role of Medical Schemes

The White Paper on National Health Insurance (NHI) proposes significant changes to South Africa's health sector, with a view to achieving universal health coverage. It proposes that under a fully established NHI system, medical schemes will only play a complementary role[1] in the financing of health care. The specific roles and limitations of medical schemes in this new dispensation is described in practical terms by the White Paper as follows:

i. Individuals will only buy PHI on a voluntary basis, and will not have the option of opting out from mandatory prepayment towards NHI [Par 52, 396 & 399]
ii. Individuals may choose not to utilise the benefits covered by the NHI Fund [Par 396].
iii. During the transition phase, PHI will play a 'supplementary'[2] role to the statutory health insurance (NHI); *therefore providing cover for services also covered by the NHI*. [Par399]
iv. When the NHI is fully implemented, medical schemes will only cover services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. [Par 399 & 401]
v. Benefits under the NHI are envisaged to be comprehensive, but some services will not be covered. "*This may be as a result of these health services not fitting into the mainstream medically necessary and efficacy-proven interventions approved for NHI"*. [Par 7, 52, 400]

The main reason provided for the change in the role of medical schemes is to ensure optimal utilisation of financial and human resources to benefit the population by: (a) eliminating the effects of fragmentation in funding pools such as inequities in access and use of health services; and (b) ensuring that people do not insure against the same healthcare costs twice [Par 397].

The implications of this proposal are that under a fully functioning NHI system, the publicly administered NHI scheme will provide comprehensive cover for health services – at all levels (primary, secondary and higher levels of care). Services not provided under the NHI will be those that are considered not to be medically necessary and efficacy-proven interventions, in the mainstream. It is only these non-medically essential and efficacy-proven interventions that will be covered by medical schemes. There will be no co-payments for health services provided under the NHI at the point of use. Individuals will have no option for buying health insurance cover for higher quality services (shorter waiting times, choice of provider, etc.) as a substitute to the NHI scheme, even after contributing to the NHI scheme. Individuals who would prefer not to utilise benefits covered by the NHI will have to pay out-of-pocket to utilise private providers for medically necessary and efficacy-proven health services.

[1] According to the White Paper, 'complementary' private health insurance covers health services that are not covered by the statutory health insurance system. International literature defines complementary insurance to cover additional costs of services (co-payments, or for utilisation outside limits) not covered by the statutory health insurance.

[2] Supplementary PHI is defined in the White Paper as PHI that "covers the same range of services as statutory health insurance, aims to increase the choice of provider (e.g. private providers or private facilities in public institutions) and level of inpatient amenities (e.g. a single room). By increasing the choice of provider, it may also provide faster access to health care. Often sold in combination with complementary and/or substitutive private health insurance.

HASA is of the opinion that the proposed role for medical schemes under a fully implemented NHI is not appropriate given the South African context. This view is also supported by empirical analysis and international experience in financing arrangements to achieve universal health coverage.

Fiscal Space and Role of Private Health Insurance

Many countries have adopted some form of pre-payment statutory health insurance system[3] (Social Health Insurance or National Health Insurance for example) to improve access and cover for health services to the population. In most of these countries, secondary voluntary private health insurance (PHI) is allowed/encouraged to serve specific purposes. The role of secondary PHI varies from country to country. PHI alongside a publicly funded system can take on three broad forms:

Substitutive: PHI that is taken as an alternative to the statutory health insurance, with the implication that those who elect to take out such coverage are partially or fully exempt from premiums or taxes associated with the statutory health insurance scheme.
Supplementary[4]: PHI that covers services in the statutory package, but the insured receive no exemption from payments to the statutory insurance system, and therefore enjoy double coverage.
Complementary: PHI that offers full or partial coverage for services excluded or not fully covered by the statutory health system

These roles are not mutually exclusive in a health system, and so it is common to find PHI playing more than one role, depending on the type of health service in question (The World Bank, 2007; Karl, 2014). For example, in Denmark, France, Luxemburg, Turkey and Portugal, PHI plays both a supplementary and complementary role. (The World Bank, 2007; Odeyemi & Nixon, 2013).

Review of international evidence on health financing shows that high-income countries are more likely to successfully finance a universal comprehensive benefit package through their statutory insurance system - from traditional financial sources such as tax revenue and pay-roll/earmarked income tax contributions. In these high-income systems, secondary private health insurance can cover what gaps there are in the statutory system – cover for co-payments, utilisation limitations, non-essential services, and quicker access to certain services.

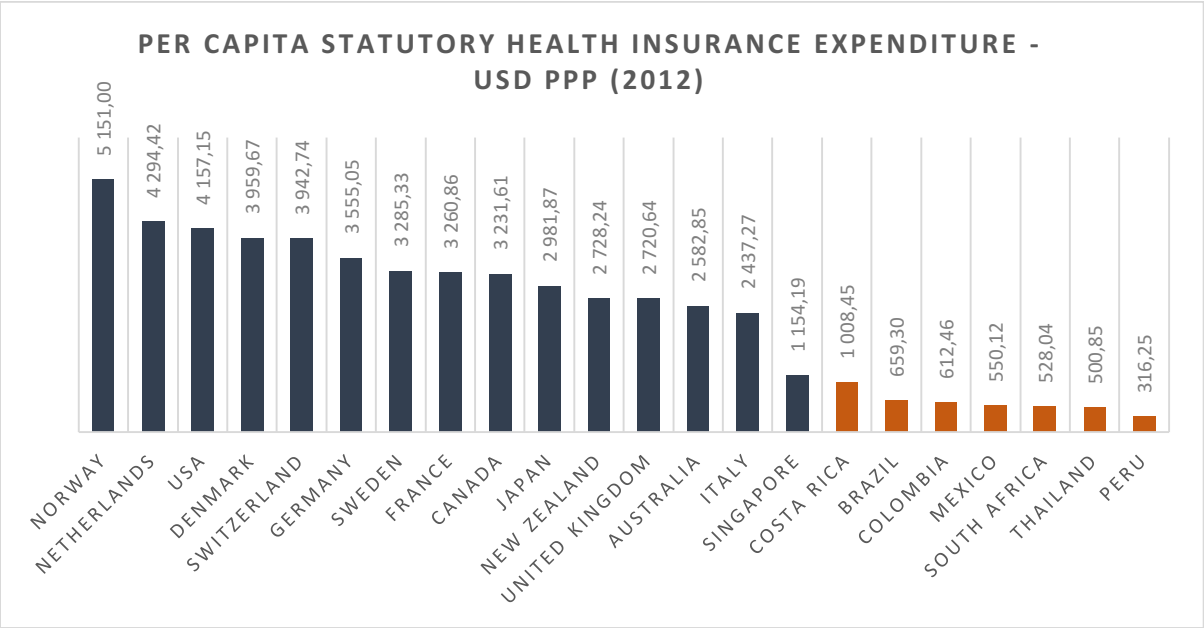
Low- and middle income countries on the other hand have much less fiscal space and often have to settle for a much narrower universal package. Concerns around financial capacity have led to an increasing concerted effort to specify explicitly an “essential” package of health care that is covered by the statutory insurance fund. PHI is then considered as a

[3] Statutory health insurance system refers to the primary publicly administered insurance system in the country, which can include contributory and tax funded sub-systems.
[4] Supplementary and substitutive private health insurance are duplicative in nature. They both provide cover for services that are covered by the statutory health insurance. The main difference is whether there is exemption from contribution to the statutory insurance scheme.

significant source of additional funding and often plays a duplicative (supplementary or substitutive) role (The World Bank, 2007).

Figure 1 below compares per capita expenditure levels for select countries that are regularly cited in global health reform discourse as pursuing or have achieved universal coverage. The data is for statutory health insurance expenditure in 14 high income countries often cited in global health reform discourse as pursuing or having achieved UHC; and 7 upper-middle income countries with similar income levels as South Africa[5]. With the exception of the USA and Singapore, all the other high income countries have achieved universal health coverage with a comprehensive package of services for their populations (Mossialos, Wenzl, Osborn, & Anderson, 2015).

Figure 1: Statutory Health Insurance Expenditure[6]



Data sourced from WHO World Health Statistics 2015

None of the upper-middle income countries have been able to achieve a universally comprehensive benefit package. Financial limitations remains the fundamental challenge (Saenz, Bermudez, & Acosta, 2010; Seinfeld, Montanez, & Besich, 2013)[7]. Average health expenditure for the statutory health insurance systems[8] of the high income countries that have achieved universal health insurance with a comprehensive package is USD 3,394; which is more than **5.5 times** the average expenditure for the middle income countries

[5] See Annex for income levels of the upper middle income countries

[6] **High income countries are**: Norway, The Netherlands, USA, Denmark, Switzerland, Germany, Sweden, France, Canada, Japan, New Zealand, United Kingdom, Australia, Italy and Singapore. **Upper-middle income countries are**: Costa Rica, Brazil, Colombia, Mexico, South Africa, Thailand and Peru

[7] See Annex for references for Brazil, Colombia, Mexico and Thailand

[8] This includes all tax-funded expenditure and expenditure from payroll tax contribution and premiums within the statutory health system. This does not include expenditure from private complementary/supplementary health insurance

(with the exception of South Africa)[9] listed. Generally, per-capita public expenditure on health is around 5 times higher high income countries compared to upper-middle income countries (World Health Organization, 2015).

Thailand has achieved universal coverage for its population, and the services insured are close to being comprehensive. However, a mix of co-payments and utilization limits are used to manage the demand for health care and associated costs[10]. The health systems of Mexico, Brazil and Colombia, are facing significant financial limitations and have consequently been unable to provide comprehensive cover to large proportions of their population. In Mexico and Colombia, the statutory insurance's inability to provide effective cover (poor quality and low access to many services) for a supposed comprehensive package has resulted in increasing number of judicial procedures taken against the state (See Annex).

In all of the upper middle income countries reviewed, secondary private health insurance is available and plays a supplementary role. This allows those who are dissatisfied with the health service and are willing to pay, to get quicker access to perceived higher quality health services and a wider choice of health providers. Also, the statutory health insurance system is mainly funded from a combination of tax revenue and mandatory payroll contributions. Another common feature of most these systems is the delineation between contributory and non-contributory insurance sub-schemes, each with their unique benefit packages (Saenz, Bermudez, & Acosta, 2010) (Seinfeld, Montanez, & Besich, 2013)[11].

Middle-income countries, with income levels similar to but higher than South Africa[12] have not succeeded in universally providing a comprehensive package of health services through their statutory insurance system.

Paragraph 7 and 432 of the White Paper on NHI proposes that the NHI will provide comprehensive health care services to the entire population with no payment at the point of use. Essentially, this means that under the NHI, there will be no use of co-payments for utilisation management or cost shifting to patients (for specific services) as is practiced even in high income countries (Mossialos, Wenzl, Osborn, & Anderson, 2015). Also, the revenue options for financing the NHI are direct and indirect taxation, payroll taxation, and premiums. In addition, in paragraph 252, the NHI is estimated to cost approximately ZAR 256 billion by 2025 (in 2010 terms). This is only a 90% increase in current public expenditure outlays. Considering the level of funding in high income countries to achieve universal coverage of a comprehensive range of health services, this proposed level of financing is unlikely to be sufficient.

In light of the analysis carried out above, South Africa cannot afford a comprehensive package of health services for all of its population, even with additional revenue from some

[9] South Africa is omitted from the average expenditure because it has not commenced financial reform to achieve UHC

[10] For example, under the UCS and SHI schemes, only 2 deliveries (under maternity) are covered, and for the SHI, a lump sum payment of 13,000 Baht is required.

[11] See Annex for references for Brazil, Colombia, Mexico and Thailand

[12] See Annex for per capita income of the upper middle income countries.

form of mandatory contribution. For South Africa, there are additional factors that further exacerbate the challenge of financial feasibility of this NHI proposal. They are as follows:

1. The South African economy has been very sluggish in the last 5 years, dropping to a GDP growth rate of 1.5% in 2014 (World Bank, 2016); and to 1.3% in 2015 (National Treasury, 2016). The government has been operating within budget deficits since the 2008/09 financial year[13], and forecasted economic growth rate for 2016 is even lower, at 0.7% (IMF, 2016). The South African economy is on the brink of a recession. There is very limited fiscal space for expansionary fiscal policies central to the implementation of the NHI proposal as outlined in the White Paper.

2. Given the above economic challenges, and other issues such as prevailing infrastructure constraints and high level of unemployment, there is growing concern that South Africa's debt credit rating could be downgraded to "non-investment grade" (often referred to as "junk status"). International credit rating agencies such as Fitch and Standard & Poor currently rate South Africa just one notch above non-investment grade (Trading Economics, 2016). A further downgrade in credit rating will significantly increase borrowing costs for the government. This concern places additional pressure to adopt a more constrained stance on fiscal policies and to focus more on promoting economic growth.

3. South Africa suffers from a very high quadruple disease burden[14] that places a huge demand on the health system. South Africa has one of the highest prevalence rates of tuberculosis (World Health Organization, 2015). In addition, by 2012, there were around 6.4 million people living with HIV/AIDS in South Africa (National Department of Health, 2014). With a population of 54.4 million, South Africa has the highest prevalence rates of HIV/AIDS in the world (UNAIDS, 2015). By mid-2013, 2.3 million people living with HIV/AIDS were on antiretroviral therapy (Simelela & Venter, 2014). Conditional grant transfers alone from the National Government to address HIV/AIDS constituted more than 8% of the entire public health budget[15] in 2014/2015.

4. The unemployment rate in South Africa is very high at around 25.5% (Statistics South Africa, 2015). There is therefore a narrow base for payroll/income related taxes.

5. The proposed NHI does not include any demand-side rationing mechanism – no co-payments at the point of use. This essentially leaves supply-side rationing (waiting lists, for example) as the only option for rationing. The White Paper however does not mention or explain these mechanisms and their potential role in the NHI.

Following from the above, it is clear that South Africa cannot afford to provide a comprehensive health insurance cover for the entire population. As observed in other upper-middle income countries, such financial constraints result in ineffective insurance cover (poor access and low quality). Therefore, limiting private health insurance in South Africa to a complementary role will leave significant gaps in the system. Without the option

[13] Sourced from National Treasury Budget Reviews from 2004 to 2015
[14] HIV/AIDS, non-communicable diseases, injuries and communicable diseases
[15] Forte Metrix calculation from National Treasury Budget Reviews.

of a prepayment private insurance scheme that provides duplicative cover (supplementary or substitutive), out-of-pocket payments for necessary medical services and catastrophic payments are likely to rise.

Pathway to UHC

Paragraph 399 of the White Paper on NHI, states that "*…in line with international experience, individuals and households will have the opportunity to purchase voluntary private medical scheme membership to complement this universal entitlement if they choose to*".

While this may hold true for some high income countries, this is not the experience of upper-middle income countries with income levels similar to South Africa. A common and rational characteristic of upper middle-income countries like Mexico, Colombia, Brazil and Thailand is their approach to achieving UHC. Health insurance/social security mechanisms that were present before the UHC policy reform were maintained, while establishing an insurance mechanism for those that had no cover. This approach to health reform indicates a recognition that pooling everyone instantaneously into a single pool significantly dilutes the benefits of the population that have had insurance cover – a welfare loss for those previously covered. Establishing a new insurance pool for the previously uninsured results in no welfare losses for the previously insured population or the previously uninsured. What is actually observed in these upper-middle income countries is that previous insurance/social security systems were automatically integrated into the statutory health insurance system. This may be a possible option for the medical schemes in South Africa.

The White Paper's proposal on NHI intends to change the role of the private health insurance sub-system from playing a supplementary role to a complementary role. This effectively reduces the scope of the available prepayment sub-system to support the statutory health insurance system. The White Paper's strategy for achieving UHC therefore goes against the lessons from international experience.

Benefit Package

Most wealthy countries seek to make the statutory package reasonably comprehensive, ensuring that all citizens are insured for reimbursement of most mainstream health care (sometimes with a modest user co-payment). Developments in health technologies however increase the opportunities to address sickness and disability, resulting in citizens increasing demands on their health care systems. At the same time, many commentators claim that the extent to which the traditional sources of finance for statutory insurance can be exploited are limited. Two policy questions therefore arise: should some interventions be removed from the statutory package, and, if so, which ones? In low-income countries, financial resources for statutory insurance, based on a narrower tax base and (sometimes) donor funds, are limited. These countries usually make no attempt to offer comprehensive coverage but instead rely heavily on personal finance of health care. Even in higher income countries, concerns around financial capacity have led to an increasing concerted effort to specify explicitly an "essential" package of health care that is covered by the statutory

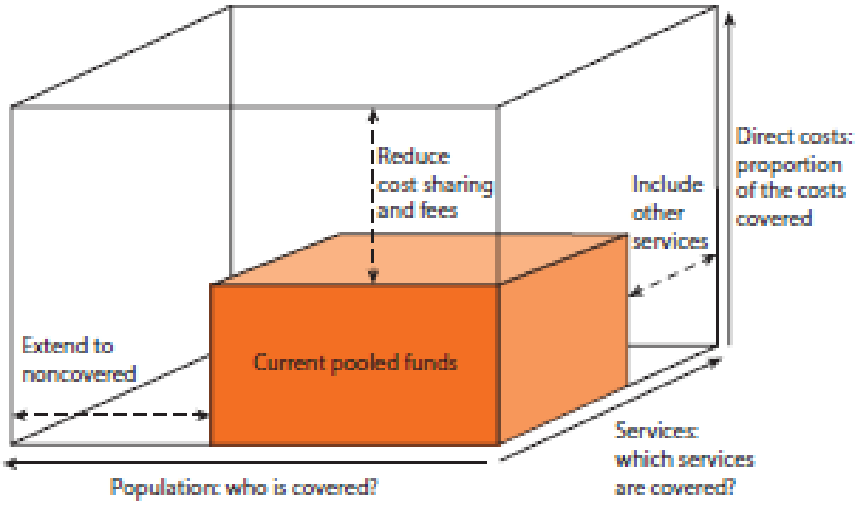
insurance fund. The use of cost-effectiveness as a basis for selecting services that are included in the statutory essential package is encouraged (The World Bank, 2007).

Lessons from the experience of upper-middle income countries indicate that the benefit package for the statutory insurance should be clearly defined. The services to be included in the benefit package should be determined on the basis of cost-effectiveness and resource availability. The benefit package of the non-contributory sub-system can be expanded as more resources become available to the health sector.

The White paper proposes a rather vague comprehensive package for all members of the population under the NHI. There is no indication in the White Paper that any analysis was carried out to ascertain which services, and what quantity can be effectively covered under NHI with an estimated budget of ZAR 256 billion which is calculated in terms of 2010 costing/price levels. The declaration of a comprehensive offering is reminiscent of the experience of Colombia and Mexico where citizens are resorting to the legal system in order to receive certain services.

The well-known dimensions of universal health coverage illustrated below, considers (1) what proportion of the population is considered, (2)what services are covered and (3) the extent of financial protection provided.

Figure 2: The three dimensions of Universal Health Coverage



In the face of resource limitations, policy makers have to decide on how much of each dimension is achieved. As deduced from analysis carried out in this section of the HASA response, no upper-middle income country has the resources to cover all dimensions. Where the entire population is targeted and there is no cost sharing at the point of use, as proposed in the White Paper on NHI, a narrower and explicit essential package rather than a comprehensive package is a wise option, especially where there are concerns around financial capacity (The World Bank, 2007).

Recommendations

International experience of upper middle income countries does offer some lessons for South Africa, and pointers on options for the way forward. Any financially viable option would have to recognize the limitations placed by the prevailing economic environment, while looking to achieve socially and politically desirable goals. This means that the role of PHI (medical schemes) should be seen from the perspective of being an additional source of funding, and therefore should provide cover that is duplicative in nature. The question that should then remain is whether medical schemes should play a substitutive or supplementary role. These options are illustrated below. In the first option, medical schemes play a supplementary role, and in the second option, medical schemes play a substitutive role.

A. The NHI scheme can remain the singular insurance component of the statutory insurance scheme (as proposed by the White Paper). Given the obvious financial limitations, the benefit package should be a narrower essential package of services, determined based on cost-effectiveness and available resources; as opposed to the comprehensive package of services currently being proposed. The benefit package should be explicitly defined, either as a positive list or a negative list. Services not included in the benefit package can still be provided by public health facilities, but with appropriate supply-side and demand-side rationing (utilisation limits, co-payments, waiting lists, etc.). The government could still impose additional taxation specifically to raise funds for the NHI. However, individuals should remain free to buy membership to medical schemes that cover services even after they have made the required contributions to the NHI. Medical schemes will continue covering services that are also covered under the NHI. This allows members of the population to avoid any potential access and quality limitations of the NHI scheme.

   The advantages of this option are:

   i. More resources are made available to the NHI, with the added benefit that a proportion of the population will contribute to the NHI but prefer not to utilize NHI services. This reduces the overall burden on the NHI system.
   ii. The availability of 'choice' to buy health services outside the NHI either through direct payment or with voluntary private health insurance increases overall societal welfare.

B. A second option is to consider integrating the medical schemes into the overall statutory health insurance scheme. Medical schemes can serve as the "contributory" sub-system within the overall statutory health insurance system. Contribution and membership to medical schemes could be made mandatory for all those deemed to have the "ability to pay" the required premiums, based on some income threshold. The new NHI scheme then provides cover to those previously uninsured, with the government making contributions per household/individual in the non-contributory NHI scheme. Essentially, contribution to medical schemes exempts individuals/households from any additional taxes/contributions for the NHI. A risk-equalization system for medical schemes could then be introduced as in Colombia (Ruiz, Amaya, & Venegas, 2007).

The advantages of such a system are:

i. The government can more effectively harness the resources available through the medical schemes environment to provide adequate cover to a greater proportion of the population than is currently covered by medical schemes.
ii. Introduction of mandatory membership and risk equalisation to the medical schemes environment will address some of the main drivers of cost per member, such as anti-selection and 'cherry picking'.

A key issue for this option is that the benefit package offered by the medical schemes environment will in all likelihood by more generous than the benefit package offered by the NHI – assuming that the NHI benefit package is defined with sustainability and effective insurance cover as important considerations.

A disadvantage of the second option is the potential for the burden on the NHI system to be much higher in relation to the first option, as there is no choice for individuals to buy cover outside the statutory health insurance system.

HASA therefore recommends that under a fully operational NHI system, medical schemes should operate in its current supplementary role.

Whether any of these option are selected or not, some important conclusive statements can be made:

1. Considering the current economic constraints and demand for health in South Africa, a National Health Insurance scheme cannot effectively offer a comprehensive package of services to the entire population. Therefore a much narrower and explicitly defined essential package is appropriate and sustainable.
2. In line with the right to access to quality care, it is therefore imperative for the population to have the choice of purchasing private health insurance cover outside the NHI, either as a substitute or supplement if they deem this necessary.
3. Transforming medical schemes from playing a supplementary role to a complementary role as proposed by the NHI White Paper will severely limit overall access to quality care and increase out-of-pocket payment for health. HASA strongly recommends that this aspect of the reform be reconsidered.
4. Implementation of such a major health reform without due consideration for the evident limitations in the system could be considered optimistic, but not responsible. Failure of this reform is likely to rob the government of support for any such reforms in the future.

Annex

Brazil: With a constitutional reform in 1988, Brazil established health as a universal social right, and the State as responsible for ensuring conditions for its full exercise (PAHO/WHO; USAID, 2008). The Sistema único de saúde (SUS) was established to meet the healthcare demands of Brazilians who do not have private insurance to cover their expenses. The SUS was initially financed mainly from compulsory contributions linked to gross revenues and net profits from companies (in addition to government budgets). Currently, the SUS has moved to become mainly publicly financed from taxes (Alves & Timmins, 2001). Before the introduction of the SUS, the INAMPS (medical care arm of the Social Security Institute) was the main player providing medical cover for the largely urban formal sector, based on compulsory contributions from employers and employees; and to a small extent resources from the Ministry of Health. Currently, the health system is a dual system. The tax funded SUS is the main provider of health services for around 70% of the population. The contributory, private sector Complementary Medical Care System (SSAM), like its predecessor, the INAMPS, provides health services to around 20% of the population, while around 14% of the population use both (Couttolenc & Dmytraczenko, 2013). Private health insurance accounts for half of the country's health expenditure. Although private health insurance was legislated in 1988 to play a supplementary role, it however plays a more duplicative role. A challenge that faces the health system is that to operationalize the right to health in the 1988 constitution, the government has maintained the legal position that anyone can be treated for free under the SUS based on an open-ended benefits package. The SUS has not been able to provide all services for everyone and many patients have resorted to courts to seek access to expensive drugs or treatments, resulting in judicial mandates that pose an increasing burden on SUS finances. Interestingly, in spite of the open-ended service package, the SUS pays or reimburses providers for a limited list of services. The SUS is facing severe financial constraints order to meet its mandate, and additional public financing is needed. However, it is also noted that the system is run very inefficiently and so more health services can be provided using the same amount of resources. (Gragnolati, Lindelow, & Couttolenc, 2013).

Colombia: The statutory insurance system - General Social Health Insurance System - has two components. A contributory regime (CR) funded through earmarked payroll tax and a subsidized regime (SR) funded through a combination of public resources from all levels of government. In 2011, the CR covered 47.4% of the population, while SR covered 39.9% of the population. By 2014, both regimes covered 96.6% of the population (Torres & Acevedo, 2013). Secondary private health insurance is permitted, but individuals are only eligible for buying private health insurance if they are enrolled in the CR. Private plan benefits focus on more liberty in choosing physicians, better inpatient accommodations and less waiting time to access diagnosis and out-patient procedures (Ruiz, Amaya, & Venegas, 2007). In 2012, around 9% of total health expenditure was accounted for by private health insurance (World Health Organization, 2015). The CR has a fairly comprehensive benefit package, while the SR initially covered only basic primary health care services and selected high-cost catastrophic services (Torres & Acevedo, 2013). Individuals in both the CR and SR have free choice of a range of public and private insurers (Ruiz, Amaya, & Venegas, 2007). In 2012, the government passed regulations that called for all citizens to receive the same benefit

package. Deficiencies in the provision of timely and quality services included in the benefit package of the CR has spurred legal challenges. Between 2002 and 2005, services provided due to legal challenges accounted for around 25% of expenditure for insurers in CR. Financial sustainability is of particular concern for Colombia's health system. In recent years, the health system has received substantial increases but continues to run a deficit. Between 2010 and 2014, combined expenditure on CR and SR has increased by around 25% in real terms. Many insurance firms (EPS) are failing due to financial losses resulting mainly from higher increases in expenditures relative to revenues. Operational deficits of public hospitals reached about USD 62 million in 2012. An assessment of the financial conditions of 955 public hospitals concluded that 45% of public hospitals were at high risk of financial breakdown in 2014. The government is aware of the need to increase allocations to health, especially to equalise benefits, and is looking for additional sources of revenue to finance the health sector. The introduction of 'sin-taxes' is currently being considered. The financial challenges faced in Colombia have also been associated with poor financial oversight and accountability of private health insurers that dominate the statutory insurance market (Londano & Molano, 2015). In a recent assessment of Colombia's health system, a key recommendation for improving health system sustainability was for the government to redefine the basic benefits package as an exclusion list (OECD, 2015).

Thailand: The health system is credited with achieving universal coverage in 2002. The statutory health insurance system is made up of three distinct public health insurance schemes. The SHI covers private-sector employees (without dependents except maternity benefits; CSMBS covers civil servants, pensioners and their dependents (parents spouses and not more than 3 children less than 20 years old); and the remaining population is covered by the UCS. The benefit package for all three insurance schemes are fairly comprehensive – covering ambulatory and inpatient care, including emergency and rehabilitation services. Also, all three schemes apply a negative-list concept. The negative list includes services without proven clinical effectiveness, or those that are considered to be non-essential such as plastic surgery. However, a mix of co-payments and utilization limits are imposed for certain conditions. Also, each of the insurance schemes contract with its own unique mix of public and private providers depending on the level and type of care. The CMBS and UCS are general tax-financed non-contributory schemes, while the SHI is funded by a tripartite payroll taxes with equal contributions from employers, employees and the government. CMBS covers 9% of the population, while SHI and UCS schemes cover 16% and 75% of the population respectively. Secondary voluntary PHI is available for those who can afford the premiums. They offer similar benefits to the three public schemes, but with more choices of private hospitals. Private voluntary health insurance covers 2.2% of the population. Since the introduction of the UCS and the achievement of universal coverage, overall public spending on health has increased significantly. However the growth in overall health expenditure is considered to be within the government's fiscal capacity because of the high economic growth of the country (Jongudomsuk, et al., 2015). Public health expenditure per capita increased from USD 135 in 2000 to USD 527 in 2013 (almost 4x increase); within this period, GDP growth averaged around 4.1%, and GDP per capita increased by 62%[16] (World Bank, 2016).

[16] All figures are in 2011 constant prices using Purchasing Power Parity.

Mexico: Seguro popular (SP) was introduced in 2004, which extended publicly funded health insurance to 50 million citizens previously uninsured by 2014 (OECD, 2016). Prior to this, Mexico had two main social security insurance systems. IMSS covered unions and workers in different private sectors; ISSSTE provided cover to state workers; and other smaller schemes covered special groups such as the navy and the army. Both the IMSS and the ISSSTE provide health services themselves, rather than contracting out (Frenk, Gonzalez-Pier, Gomez-Dantes, Lezana, & Nkaul, 2006). The current statutory health insurance system comprises mainly of these three sub-systems. The three systems of insurance have a tripartite financing arrangement. The federal government finances a portion of the insurance contribution; employers contribute a portion; and the employees contribute a portion. For the SP, the entire contribution is from general tax revenue. Private health insurance is voluntary and duplicative and covers around 2 to 3% of the population (Knaul & Frenk, 2005). The SP has a defined positive list of available interventions, which is expected to grow over time to match the benefit package of the IMSS and ISSSTE. In contrast, the IMSS and ISSSTE cover, in theory, any and all health care needs. This entitlement on paper has been difficult to uphold due to gaps in accessibility and quality. A review of the health system shows that out-of-pocket spending in Mexico constitutes 45% of health system revenue, a signal of the failure of the health system to provide effective insurance, high quality services or both. Part of the reason for the high OOP spending may be dissatisfaction with the quality or accessibility of services provided by institutions to which individuals are affiliated. A key recommendation for the Mexican health system is to consider defining more explicitly the health care covered by the social security institutes, to ensure that only high-value services are funded – reducing publicly funded benefit package, and then to explore the use of supplementary private health insurance to cover services deemed to be of marginal value. Also, the government has been encouraged to allocate more resources to the health sector. Publicly funded health is 3.2% of GDP, the lowest for all OECD countries. (OECD, 2016).

Table 1: Per Capita Income (Purchasing Power Parity)

Upper-Middle Income Country	**GDP Per capita Current USD PPP (2014)**
Costa Rica	14,918.08
Brazil	15,838.02
Colombia	13,357.15
Mexico	17,107.91
South Africa	13,046.21
Thailand	15,735.07
Peru	11,988.93

Source: (World Bank, 2016)

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