How ready is South Africa really for a National Health Insurance?

(Word Count: 3375 including the in-text references, all the figures, but excluding the reference list)

1. Introduction

The idea of a Universal Health Coverage (UHC) has captured a significant amount of attention globally; even South Africa has proposed its own version of the UHC through the National Health Insurance (NHI). The publication of the Green Paper in 2011 proposing the policy has been welcomed with mixed emotions; there are strong voices from those who are for and those that are not. Following the Apartheid-era there has been a significant gap between the rich and the poor even after 22 years into democracy South Africa is battling one of the highest income inequalities in the whole world measured by the GINI index at 63.38 by 2011 (World Development Indicators, 2016).

This has led to the lack of access to health care as well as limited to no health care expenditure risk coverage for the poor. The poorest being the majority. Consequently, the poor are restricted to basic health services. "Although South Africa is considered a middle-income country in terms of its economy, it has health outcomes that are worse than those in many lower income countries" said Coovadia, et al. (2009). The Department of Health (2011) describes the disparity as a mal-distribution and condemned it as favouring the private sector professionals.

Supposedly deriving its mandate from the National Development Plan (NDP) the Department of Health (2011) through the Green Paper states that:

"National Health Insurance (NHI) a is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families."

Aligned with global efforts such as the millennium goals of UHC, stating its case the NHI is proposed on the basis that health care is a social investment and should not be left to market forces (Department of Health, 2015). The Green Paper condemns the current two-tier system of the health system as divided according to socio-economic stance; the NHI policy intends to abolish the two-tier system for a single payer.

Amongst those in support of the NHI is the archbishop Desmond Tutu, who argues that the insurance is not only welcome but that it is critical in the provision of basic human rights; stating that it is immoral that 80 percent could have only access to the merely the basic health care, while less than 20 percent affords the world's best medical treatment (TMG Digital, 2016). Furthermore, the Department of Health (2015) argues that South Africa's medical scheme spending in the private sector is globally high, over six times that of the OECD[1] countries and financing only 16.2 percent of the population. Whereas, the public sector is experiencing challenges in its multiple funding pools resulting in less effective planning and funding service uncertainties across its three spheres. And as such, the poor and unemployed do not have financial risk coverage for their health expenditure and are thus deprived of their health needs.

Even, though the NHI is a plausible proposal considering the skewed nature of South Africa's income distribution, its affordability and success of equitable distribution are well in question. This essay uses the National Health Insurance Schemes (NHIS) in Ghana and Brazil's Unified Health System (SUS) to draw conclusions regarding South Africa's adoption of the NHI policy. I therefore, conclude that the adoption of the NHI should be delayed until other related issues are addressed, amongst others; the lack of human resources, the negative impact the policy will have on the poor and the lack long-term financial guarantee to finance the scheme.

Section 2.1 discusses the reasons against the NHI, Section 2.2 evaluates Ghana's NHIS and Brazil's SUS, followed by Section 2.3 which looks at South Africa's health financing versus the NHI proposed financing. Section 2.4 evaluates South Africa, Brazil and Ghana development indicators and Section 3 provide recommendations and conclusion.

2. Body

2.1 Arguments against the NHI

The following are listed as the NHI features[2] by the Department of Health (2015); 1) universal access, 2) mandatory prepayment of health care 3) Comprehensive Services, 4) Financial risk protection, 5) Single fund 6) Strategic purchaser and Single-payer. Despite, the sensible reason for the adoption of the NHI as discussed in the introduction,

[1] Organisation for Economic Co-operation and Development

[2] For more details on the features see the Department of Health (2015)

the policy is not without challenges. The following are some of the majors challenges facing the NHI:

The lack of efficiency in the state-run operations

The argument regarding the government's efficiency in the administration of the big single pool funds is warranted, this given the unpleasant state of some of the state operated enterprises such as ESKOM. There is no certainty in the government's ability to efficiently and effectively operate such a large fund.

The lack of human resources

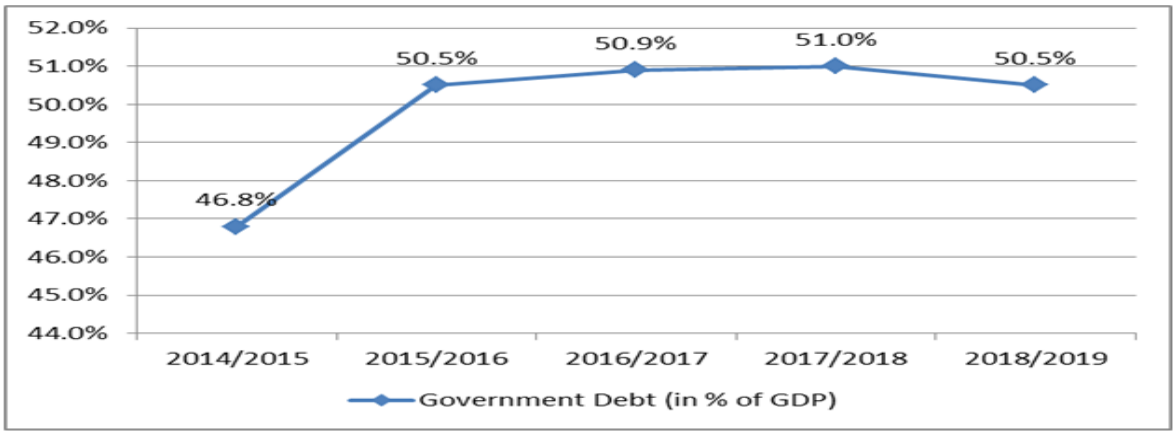
Currently, most public hospitals and clinics are understaffed and under resourced. There is lack of attraction to the public sector by practitioners in the private even though there is a massive shortage in the related services. There seems to be reluctance to join the public sector by doctors in the related areas. Furthermore, the strikes prevailing now and then in the public sector serve as a disincentive.

The lack financial resource to finance the NHI

Not too long ago South Africa was downgraded by the big three credit rating agencies; Standard & Poor's (S&P) to BBB- with negative outlook, Moody's to Baa2 with negative outlook and Fitch group to BBB- with stable outlook. The country's budget deficit was at 4.30 percent of GDP by 2013 (National Treasury, 2015) and the government debt averaged at 29107.94 USD Million between 2002 and 2015 (SARB, 2016).

The national debt attracted attention from the finance office as the Minister Pravin in his February budget speech stated that "We cannot spend money we do not have. We cannot borrow beyond our ability to repay. Until we can ignite growth and generate more revenue, we have to be tough on ourselves." Figure 1 shows the government debt forecasts as a percentage of the GDP.

Figure 1: South Africa government debt forecast



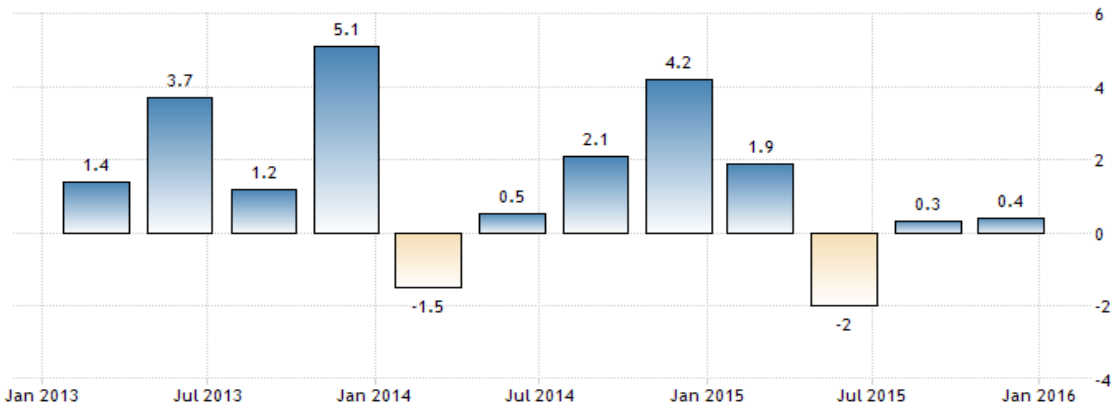
Source: National Treasury (2016)

The above Figure shows that the government forecasts a decline in the national debt by 2019 following the governments' intentions to manage the state workforce to reduce unnecessary expenditure. However, this forecast is not supported by the forecast of the IMF which predicts that an increase to 54.32 percent by 2020 (IMF, 2015). The current and future state of the national debt poses as major constraint to the NHI policy, despite allocating a R4.5 billion directed to the NHI related activities; consequently the Minister explained that "These are not straightforward reforms. Health financing is complex, because the demands unavoidably exceed available funds. This is the case even in advanced rich countries."

The low economic growth

South Africa is experiencing low economic growth level as can be seen in Figure 2 below.

Figure 2 South Africa's economic growth rate from 2013 to 2016



Source: www.tradingeconomics.com

In addition, to this low growth unemployment has been stable at high levels, currently at 26.7 percent (StatsSA, 2016) placing a constraint to revenue collection. Furthermore, business confidence has never been stable throughout the years and it has remained low at 36 in 2016 following a sharp decline in 2015[3]. This hinders capital flow to South Africa and increases the current account deficit risk which is mainly financed through external capital.

As such, depends on economic growth as an indicate of successful funding of the NHI as suggested by the White Paper is not justified given the low growth South Africa has been experiencing. This coupled by declines in major labour absorbing sectors such as the mining and the agricultural sectors which is affected by the drought serves as evidence that the scheme will merely drive the budget deficit and taxes up without any promise to re-finance later through an improved economic growth.

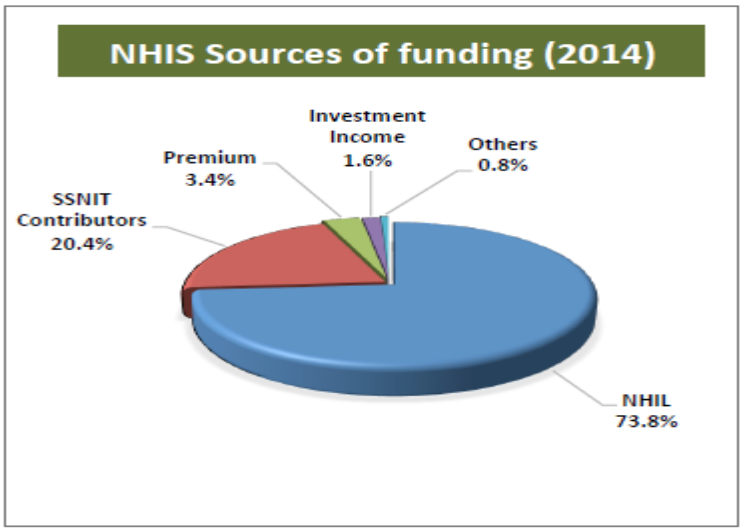
[3] Resulting from the "9/12" sacking of the former finance minister Mr Nhlanhla Nene, which lead to the rand tumbling to R15/$ a fall by 5.7 per cent to the dollar (Business day, 2015).

2.2 Ghana (NHIS) and Brazil (SUS)

2.2.1 Ghana's National Health Insurance Scheme

Ghana adopted the National Health Insurance Scheme (NHIS) in 2005, the NHIS provides quality basic health care financing for the Ghanaian residents (www.nhis.gov.gh/nhisreview.aspx). Figure 3 below shows how the NHIS is funded.

Figure 3 Ghana's NHIS sources of funding in 2014



Source: Jehu-Appiah (2015)

The healthcare system has five levels of providers: health posts which are first level primary care for rural areas, health centres and clinics, district hospitals, regional hospitals and tertiary hospitals. By 2012 the scheme had over 8.8 million active members which then represented 35 percent of the population (www.nhis.gov.gh/nhisreview.aspx).

Even though the NHIS is mandatory, in Ghana those in the informal sector have to pay a premium Amporfu (2013). Amporfu (2013) said that "The ultimate goal of the Scheme then is to provide all residents with access to adequate health care at affordable cost." Amporfu studied the vertical and horizontal equitability of the revenue collection in achieving the universal coverage. The study applied the Kakwani index[4] for the vertical and horizontal coverage. The author finds that both the vertical and horizontal revenue collections are inequitable. Consequently, the study holds that "the small majority of the poor were likely to incur catastrophic expenditure from paying the premium a situation

[4] For a detailed discussion on these methods see Amporfu (2013)

that could impede the achievement of the universal coverage." The study showed that the premiums vary according to the areas. Dixon, Tenkorang and Luginaah (2013) confirm that currently the NHIS has an unequal enrollment according to the different areas. Similar to Ghana, South Africa is also dominated by citizens residing in townships and rural areas who cannot afford to travel to the urban areas to receive medical care.

Willams and Alatinga (2014) conducted a study on the impact of the NHIS on the poor people in Ghana. They find that the NHIS benefits the poor less and condemned it for failing to achieve its main objective of socio equity and that the scheme is more concentrated in the urban areas. They argue that the NHIS needs to develop a criterion to identify poor people to be exempt from the health insurance premium.

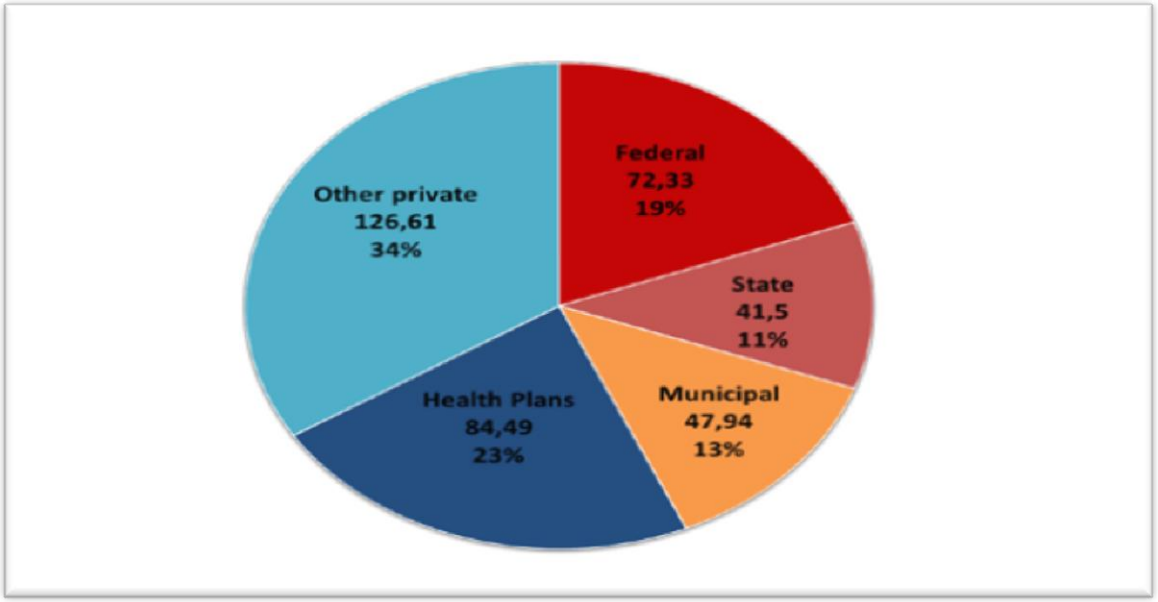
Above all, Korankye's (2013) study found that the NHIS is facing finance challenges through inadequate sources of funding and insufficient premium. The study commands the NHIS as important for achieving equitable access to health without financial barriers, however, the enrolment by choice is denounced by the study for undermining the goals and the achievement of universal coverage

2.2.2 Brazil National Health System

Similar to South Africa, Brazil also emerges from a comparable socio-economic structure of historically high social inequality and the exclusion of the majority from access to quality health care. Brazil adopted the Unified Health System (SUS) for similar reasons raised for the proposed South Africa's NHI policy. The lack of financial risk protection, limited access to care for the poor and clinics and hospitals mostly centred in urban areas (Harvard School of Public Health, 2013). Brazil's SUS provides primary care and is a two-tier system a mixture of public and private services (Harvard School of Public Health, 2013) and is the world's largest public health system (Deloitte, 2015).

Brazil's SUS is funded through general taxes, out-of-pocket spending, social insurance contributions and employer's health-care spending (Harvard School of Public Health, 2013). The Harvard School of Public Health stated that the SUS remains underfunded through the use of general revenue and that actually "private spending" is higher. Figure 4, below shows the Brazil's health care funding sources in 2011.

Figure 4: Brazil's Health Care funding by Source in 2011



Source: Harvard School of Public Health (2013)

From Figure 4, above we can see that other private spending account for a large portion of Brazil's SUS. The scheme is applauded for its major health care restructuring and improving the population health. A key to the success of this policy are the Family Health Programs (PSF), that is to each PSF clinic has family heath teams, which comprise of 1 doctor, 1 nurse, 1 auxiliary nurse and 4 to 6 community health workers (Harvard School of Public Health, 2013).

However, both Brazil's private and private health care have been found to be "either very bad or mediocre" (Deloitte, 2015), thus lacking quality care (Harvard School of Public Health, 2013). Patients frequently complained about long waiting times, and difficulties accessing the complex procedures such as: dialysis, surgery and chemotherapy (Deloitte, 2015). Amongst, these challenges amongst is funding (Harvard School of Public Health, 2013) hindering endeavours to improve national level standard care (Deloitte, 2015).

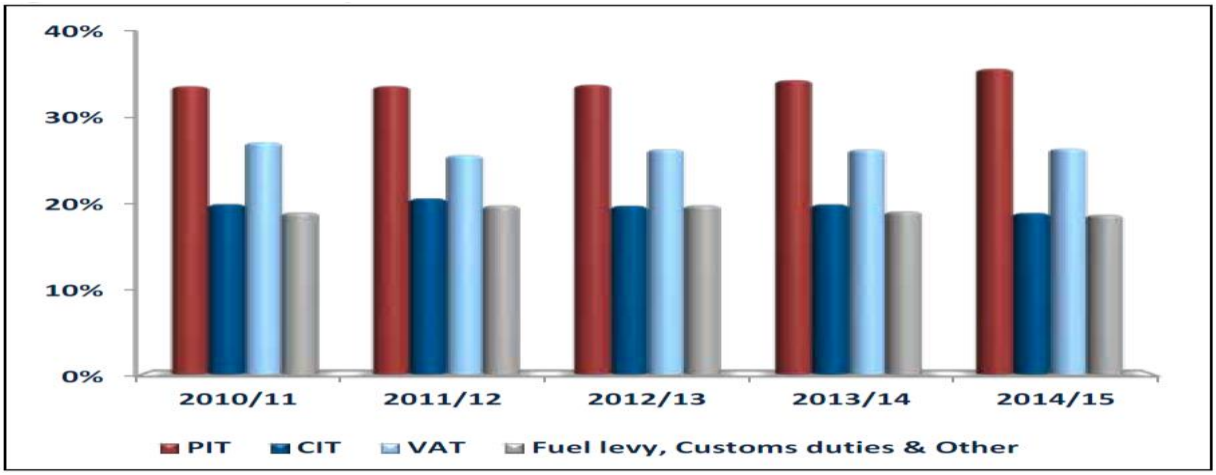
Also, the SUS contracts some of its patients to the private sector, while the payment from the SUS is deemed insufficient for the private sector to provide adequate care to these patients (Harvard School of Public Health, 2013). Consequently, Deloitte pointed out that the partnership between the public-private sector needed to be strengthened to enhance and expand the care.

To summarize Brazil's SUS, Almeida, Travassos, Porto and Labra (2000) said that "Even though in the Constitution the term "equity" refers to equal opportunity of access for equal needs, the implemented policies have not guaranteed these rights. Underfunding, fiscal stress, and lack of priorities for the sector have contributed to a progressive deterioration of health care services, with continuing regressive tax collection and unequal distribution of financial resources among regions. The data suggest that despite regulatory measures to increase efficiency and reduce inequalities, delivery of health care services remains extremely unequal across the country. People in lower income groups experience more difficulties in getting access to health services. Utilization rates vary greatly by type of service among income groups, positions in the labor market, and levels of education." The above long quote clearly contradicts the praise that the White Paper affords Brazil's health care system in support of the adoption of the NHI.

2.3 South Africa's health financing versus the NHI proposed financing.

National tax collection accounts for 95.6 percent of South Africa source of revenue (National Treasury, 2008). Tax revenue as a percentage of GDP in SA has not changed much since 2005 at 24.8% and 25.7% in 2015 (StatsSA, 2015). Figure 5 below shows the composition of South Africa's tax revenue from the 4 main sources of revenue.

Figure 5: South Africa's tax revenue composition between 2010 and 2015



Source: National Treasury and the South African Reserve Bank (2015)

Figure 5 shows that the (PIT) has a larger contribution to the tax revenue, followed by (VAT) and then a slighty equal contribution from the (CIT) and fuel levy, Cunstoms duties & other.

Currently, the South Africa's health care financing is composing of the public sector expenditure on health from the general revenue, the private sector expenditure financed out of medical schemes and also from the out-of-pocket payments (OOPs) (NH1, 2011). The Department of Health (2015) denounces the current financing system as being disadvantageous to the poor since there is significantly high financing through medical schemes and OOPs. The desire of the NHI as outlined by "The introduction of NHI is premised on a number of key interrelated elements…" as found in page 21 of the Department of Health White Paper (2015) are plausible.

However, condemned the current multiple-payer system; the NHI still faces a one major challenge "funding". The Department of Health (2015) does not provide sufficient evidence as to whether the current system is readily convertible into a single-payer without severe consequences on the tax revenue collection. It turns out that the NHI proposes to finance the unitary-payer system through increased taxation.

2.4 South Africa, Brazil and Ghana Indicators

In Table 1 below I compare some critical variables to analyses South Africa's current health care position versus Brazil and Ghana. Due to the difficulties in the availability of data, some of the data points in the Table are not direct correspondents. Therefore, in those cases I rely on reasonable extrapolations and likelihood.

Table 1, South Africa, Brazil and Ghana Indicators

Indicators	**South Africa**	**Ghana**	**Brazil**
	2005	**2011**	**2012**
Hospital beds (per 1,000 people)	2.8	0.9	2.3
	2014		**2013**
Specialist surgical workforce (per 100,000 population)	11.53105441	No data	31.9306387
	2014	**2014**	**2014**
Population, total	54001953	26786598	206077898
	2014	**2014**	**2014**
Health expenditure, total (% of GDP)	8.79698456	3.55729189	8.32283359
	2013	**2011**	**2012**
Tax revenue (% of GDP)	25.49459392	14.86579036	14.093735
	2013	**2010**	**2013**
Physicians (per 1,000 people)	0.776	0.096	1.891
	2014	**2014**	**2014**
External resources for health (% of total expenditure on health)	1.83996359	15.37720781	0.13458368
	2011	**2005**	**2013**
GINI index (World Bank estimate)	63.38	42.77	52.87

Source: World Development Indicators (2016) (Own Tabulation)

The Table shows that South Africa's population is larger than that of Ghana, however, significantly lower than Brazil's. South Africa's Gini index appears to higher than for both Ghana and Brazil at 63.38 percent in 2011. Hospital beds in 2005 were 2.8 per 1000, compared to 0.9 in 2011 for Ghana and 2.3 in 2012 for Brazil, it is likely that there was an increase over the period most likely exceeding those in Brazil by 2012.

Health expenditure shows that South Africa spends more on health than Ghana and Brazil as a percentage of GDP at 8.8 percent in 2014; showing a reliance on GDP growth for its health care expenditure, for which is currently low as discussed in Section 2.1. Also, despite Ghana's NHIS it still depends on external resources for health care expenditure at 15.4 percent of the total health expenditure, followed by South Africa at 1.8 percent. More importantly, South Africa's lack of human resource is confirmed by the number of physicians available per 1000 people in South Africa at 0.776 and while Brazil has a large population it stands at 1.9 in 2013.

As such, Table 1 results together with Section 2.2 findings do not provide any compelling evidence regarding the success of adopting a national health insurance.

3. Conclusion and Recommendations

Given the above discussion here are four reasons why the NHI will remain a good idea theoretically in South Africa's context until the major stumbling blocks discussed in Section 2.1 are addressed.

1. **The tax collection will be adversely affected**

   Given the already narrow tax base, increasing taxes particularly VAT and fuel levy taxes as proposed by the NHI will only place a burden on the poor, who will have to pay more for food and transport. This implies that the poor will be less likely to afford to travel to good serviced health care centres leaving them with same old understaffed, under resourced public health care centres in the villages and townships.

2. **The system does not promise to be equitable**

   Evidence from Brazil and Ghana do not support the claims of enhanced equitability from both the analysis of these countries, it is notably that the poor continue to endure more costs and less access to better health care services.

3. South Africa's economic growth is currently low

South Africa has been experiencing low growth levels; this hinders any promises of financing coming from improved economic growth. Thus, if the GDP growth rate is used as an indicator for sustainable funding then at the moment it certainly does not support the NHI.

4. Lack of human resources

The evidence from Brazil and Ghana shows that availability of human resource is critical to the success of any UHC, in which case South Africa still falls short in this regard. There appears to be no incentive whatsoever from the private sector practitioners to go to the public sector health institutions. Thus, South Africa lacks dearly in human resources.

I conclude that the proposed NHI should be delayed until the four issues raised above are addressed. Meanwhile, the government should look into bridging the human resources gap between the private and the public sector to mitigate any disparities in the quality of services provided between the two camps. Also, trimming down the current unemployment is critical to ensure a sustainable funding pipeline for the National Health Insurance through increased tax rates in the future. ***Otherwise, the poor will continue bearing even greater costs!***

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