POSTGRADUATE ENTRY

National Health Insurance for South Africa: affordability and funding

(3763 words)

1 INTRODUCTION

The idea of introducing and implementing a National Health Insurance (NHI) system for South Africa is not new, but has gained renewed momentum with the publishing of the Green Paper on NHI in South Africa (the NHI Green Paper) in 2011 and the White Paper on NHI for South Africa (the NHI White Paper) in 2015. Universal health coverage for all citizens is an ideal that South Africa is committed to and many countries have indeed implemented such a system successfully. Given the dismal state of the public health care sector in South Africa and the growing divide between the rich who access the private sector and the poor who has no better option than the public health sector, some policy intervention is required.

This essay will critically consider whether NHI is the correct service delivery model for South Africa at this stage and more importantly, whether it is affordable, given the fiscal constraints faced by the country. Reference will be made to international experience in this regard, and lessons that could be relevant for South Africa will be considered.

2 THE HEALTH CONUNDRUM IN SOUTH AFRICA

Before looking at the specific features of the NHI, it is important to understand the rationale for introducing such a program in South Africa.

2.1 The public and private sector health divide

There are several fundamental problems facing the delivery of health care in South Africa. The most important however is the skewed distribution of health care resources. In this regard, the recent NHI White Paper (Republic of South Africa, 2015: 40) states that: “South Africa spends 8.5% of GDP on health and 4.1% of the GDP is spent on 84% of the population, the majority utilizing the public health sector whilst 4.4 % of its GDP is spent on only 16% of the population in 2015/16... This type of a

financing system disadvantages the poor and leaves many citizens at a high risk of financial ruin due to catastrophic health expenditure"

In a recent OECD study on health care in South Africa, it was reported that: "Private voluntary health insurance accounts for 41.8% of total health spending, which is more than 6 times the 2013 OECD average of 6.3%... Despite high levels of expenditure (41.8%), voluntary health insurance serves a smaller share of the population (17%) compared to OECD countries" (OECD, 2016:8-9). This shows that the relative size of private health insurance is too big.

These aggregate figures, however, do no portray the whole picture. The quality differences between the public and private health care sectors are well known. This has been acknowledged by the Minister of Health, stating that access to the public health sector is constrained by the lack of quality services and that this is one of South Africa's major health reform challenges (Motsoaledi, 2013). Therefore, many uninsured patients also access the private sector seeking quality care. It is therefore not surprising that South Africa's private health care system is both supplementary and duplicative (OECD, 2016:10). In fact, the private health sector plays a pivotal role in assisting the government in the provision of quality health services to South African citizens.

The high level figures quoted in the OECD report, i.e. 41.8% of health care expenditure being spent on 17% of the population, must therefore be put in context. The richest 20% of the population contribute more than 80% to total health financing in South Africa, via different forms of taxes and health expenditure. This richest quintile in turn receives only 36% of total health benefits, indicating significant cross-subsidy in the health sector as a whole. Also, if one takes into account those who access the private health care sector (predominantly accessing practitioners such as GPs and dentists) by means of out-of-pocket spending (i.e. who are uninsured), it is estimated that (in 2012) the private sector provided primary

health care services to 28%–38% of the South African population (Econex, 2009). This again shows that there is a demand for quality care outside of the public sector.

The question therefore is: is the NHI the solution to the problem of inequitable distribution of resources between the public and the private sector.

3 NHI AS A SOLUTION TO THIS PROBLEM

Several health reform measures have been contemplated by government since as early as 1928 to address the inequality in health care spending and specifically the lack of quality care in the public sector. While previous health reform plans have focused on a Social Health Insurance (SHI) system, where the employed make mandatory contributions to a publicly funded insurance pool, the focus is now on the NHI to deliver the necessary health reforms.

The NHI plan came under the spotlight when the ANC (African National Congress) reaffirmed their commitment to the establishment and implementation of the NHI system at their 2007 National Policy Conference in Polokwane (ANC, 2007). As a result the Ministerial Advisory Committee on NHI (MAC) was established with the mandate of providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system reforms and matters relating to the design and roll-out of NHI (Green Paper, 2011:15). Since the 2007 Polokwane conference two important policy documents have provided further details: the NHI Green Paper (2011), followed by the NHI White Paper (2015).

The NHI Green Paper proposes that a single NHI Fund be established by the end of the first phase of the NHI (5 years after implementation) with provincial offices established at the end of the second phase (10 years after implementation). It looks at, *inter alia*, the health care benefits under NHI, the payment of providers under NHI, the unit of contracting providers of health care services and the piloting of NHI. It also mentions that the necessary legislature should be created to establish this fund.

The NHI White Paper furthers the process by introducing new aspects, such as the establishment of a National Health Commission, the implementation of National Quality Standards for Health of the principles of funding for and the pooling of funds under the NHI. It also builds on the NHI Green Paper by dealing with the contracting of health service providers in more detail, as well as dealing with user charges in greater detail and the patient registration systems.

In a statement by the Minister of Health (Aaron Motsoaledi) about the NHI White Paper he mentions that it is a widely accepted international principle that health care is a human right that everyone is entitled to and consistent with the Constitutional commitment of the state (Section 27, The Constitution of the Republic of South Africa, 1996) (Motsoaledi, 2011). Assuming that the NHI is the way to realise this human right, it is understandable that some may commend the minister and call the NHI "a revolutionary policy that places a renewed emphasis on equity and social justice in South Africa" (Naidoo, 2012: 150). But even the idealists admit that the real challenge lies in the implementation of the NHI (Naidoo 2012: 150), including the funding thereof.

The main aim of the proposed NHI is to achieve universal coverage for all South Africans (i.e. to provide universal financial protection against the costs of using health services when needed) such that even those who cannot afford to pay for health care at all or at the point of utilisation, will be able to use quality health care without the fear of financial risks and other associated losses. The rationale for this, and another way to state the Minister of Health's motivation, is the belief that health care is a so-called merit good. Economists use this term to indicate that this is a product or service that an individual or group should access based on the need for care and not necessarily because they can afford it. Therefore, the usual principle that people should pay for the commodities that they demand does not apply in the case of merit goods (Ataguba, Akazili, 2010).

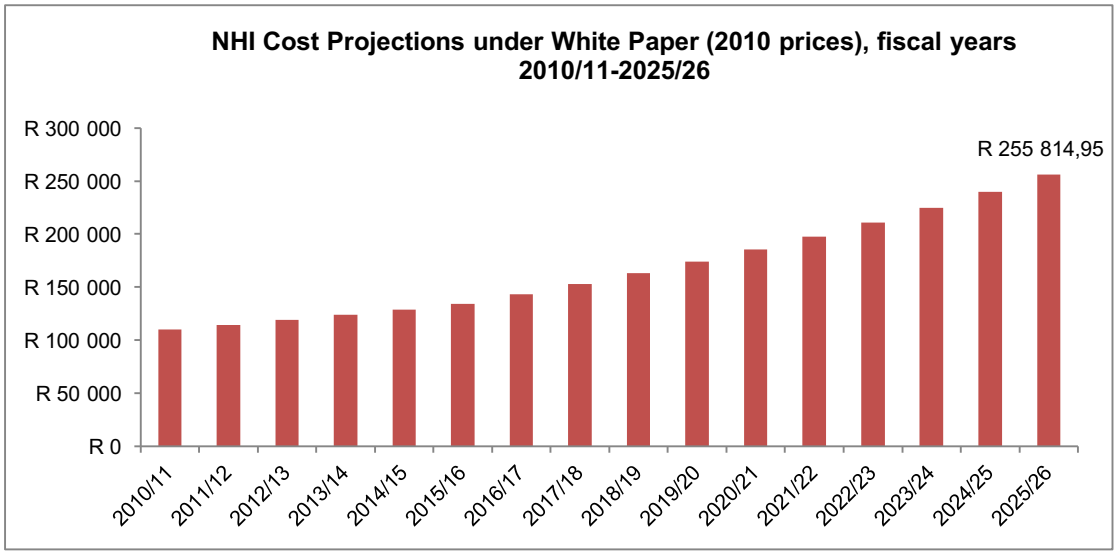
The NHI is a health financing system that is designed to pool risks and funds so that equity and social solidarity can be achieved through a single fund, while providing improved access to quality health services for all South Africans. It also aims to strengthen the under-resourced and strained public sector in order to improve the health systems' performance as a whole (NHI White Paper, 2015; NHI Green Paper, 2011). By providing a system that makes health care accessible to all it meets the other principles stated in the NHI White Paper, including equity, affordability, effectiveness and appropriateness. While affordability might refer to the price of health care to the public, the preliminary question should be whether it is an affordable system to implement in the first place. This issue is dealt with next.

4 AFFORDABILITY OF THE NHI

The NHI White Paper emphasizes the fact that a study by the World Health Organization (WHO) cautions against focusing on estimating exact costs of implementation (NHI White Paper, 2015: 45). While it might be misleading to use current costs as the basis for projecting the future, attaching a cost to the NHI is necessary to establish the feasibility thereof.

Despite this skepticism of modeling the exact costs, the NHI White Paper does include some cost estimates. The cost of implementing the NHI is estimated to be R134 324 million for the 2015/16 fiscal year, R185 370 million for the 2020/21 fiscal year and R255 815 million for the 2025/26 fiscal year (in 2010 prices). These projections mean that NHI expenditure will increase by 6.7% a year in real terms after 2015/16. According to these figures, public health spending as a proportion of the gross domestic product (GDP) would increase from about 4% currently to 6.2% in 2025/26, assuming economic growth of 3,5% per annum. A growth rate of 3.5% per annum will result in a funding shortfall of R71.9 billion by 2025/26. The following graph shows the NHI cost projections graphically.

Figure 1: NHI Cost Projections



Source: White Paper, National Department of Health, 2015

Various authors have also attempted to estimate NHI implementation costs. Van der Berg and McLeod (2009) modelled the cost of the proposed NHI on the basis of private sector data and adjusting this for the whole population. Taking a conservative approach, they assumed that the fund would provide a Basic Benefit Package (BBP) that all medical schemes would have to include. This BBP amounted to R251 billion for the full South African population (in 2009). The 2025/26 cost in the NHI White Paper does thus not seem too far off (in 2010 prices). But with South Africa's current growth prospects it is highly unlikely that the funding shortfall in 2025/26 will be R71.9 billion, assuming a 3.5% growth rate. It is thus problematic that the NHI White Paper uses only this scenario to illustrate potential funding options.

Interestingly, the total NHI cost as per the NHI White Paper (2015), is the same amount as previously shown in the 2011 NHI Green Paper. This probably illustrates the difficulty that government has in determining a credible cost estimate for such a comprehensive policy intervention.

Another complication is the fact that the current South African GDP growth outlook is much weaker than assumed in the NHI White Paper. This is evident both when considering external sources, like the World Bank (0.8% (2016) and 1.1% (2017) (Global Economic Prospects, 2016), and the International Monetary Fund (IMF) (0.7% (2016) and 1.8% (2017)) (IMF/WEO Update, 2016), but also recent updated growth forecasts published by National Treasury in the 2016 Budget Review. In the latest budget, GDP growth forecasts have been revised downward from the previous growth forecasts in the 2015 Medium Term Budget Statement (MTBPS). This is shown in the table below.

Table 1: South African growth estimates

	Growth Estimate in 2015 MTBPS	**Growth Estimate in 2016 Budget Review**
2015/16	1.2%	0.9%
2016/17	2.1%	1.2%
2018/19	2.7%	1.9%
2019/20	2.8%	2.5%

Source: National Treasury

From the table, it is clear that there has been a significant revision in the GDP growth rates forecast by Treasury for the next few years. As such, the 3.5% growth figure assumed in the NHI seems an outdated figure, even compared to Treasury's own more recent estimates. Moody's Investors Service recently said that they expect the South African economy to expand by only 0.5% in 2016 and 1.5% in 2017 (Moody's Investors Service, 2016). This means that the calculated funding shortfall of R71.9 billion is unrealistic as this was based on a 3.5% GDP growth rate.

While it is already clear that the NHI will be a significant financial burden on the state given South Africa's low growth forecasts, the calculation of the cost does not properly account for the anticipated changes in demand (i.e. utilisation) that will occur. This is problematic as the costing model that was used to calculate the cost of

the NHI in the NHI Green Paper (and consequently also in the NHI White Paper) was adopted from the approach recommended by the International Labour Organisation (ILO), which assumes that total expenditure is a product of user population, service utilisation rates and unit costs. The problem is that the NHI Green Paper assumed that the expected increase in utilisation would be comparable to the utilisation increases that were experienced in Thailand when universal health coverage (UHC) was introduced. The South African cost estimates are thus based on utilisation increases experienced in Thailand after the introduction of UHC, which is an inappropriate comparison if one considers South Africa's unique burden of disease.

South Africa is considered to have a quadruple burden of disease: the HIV/AIDS epidemic alongside a high burden of tuberculosis (TB); high levels of violence and injuries; pre-transitional diseases (i.e. communicable diseases, maternal and perinatal conditions, as well as nutritional deficiencies) and a growing burden of non-communicable diseases (NCDs) (Econex, 2009). This quadruple burden of disease makes it difficult to predict how demand will increase when health care is provided free of charge for all citizens.

To illustrate, comparing Disability Adjusted Life Year (DALY) compositions and counts for South Africa and Thailand, show how they differ. DALYs are considered a suitable method to quantify a country's burden of disease. The WHO explains that a DALY can be thought of as one lost year of "healthy" life and that the sum of these DALYs across the population can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. South Africa's DALY count per 100 000 of the population is 62 419, while Thailand's count is about half of that, 31 945. The following table shows the breakdown of DALY figures for South Africa and Thailand.

Table 2: Breakdown of DALY figures for South Africa and Thailand

	South Africa	Thailand
HIV/AIDS	22 471 (36%)	1 597 (5%)
Other communicable diseases	11 859 (19%)	4 153 (13%)
Non-communicable diseases	22 471 (36%)	22 042 (69%)
Injuries	5 618 (9%)	4 153 (13%)

Source: WHO, 2015

It could therefore be expected that the cost of the NHI would be even higher given South Africa's burden of disease and potential increase in demand for free (and quality) health care. As previously pointed out, while accessing the public sector is already free of charge, the main problem is the quality differences between the public and private sectors.

5 MOST APPROPRIATE FUNDING MODEL – SOME INTERNATIONAL COMPARISONS

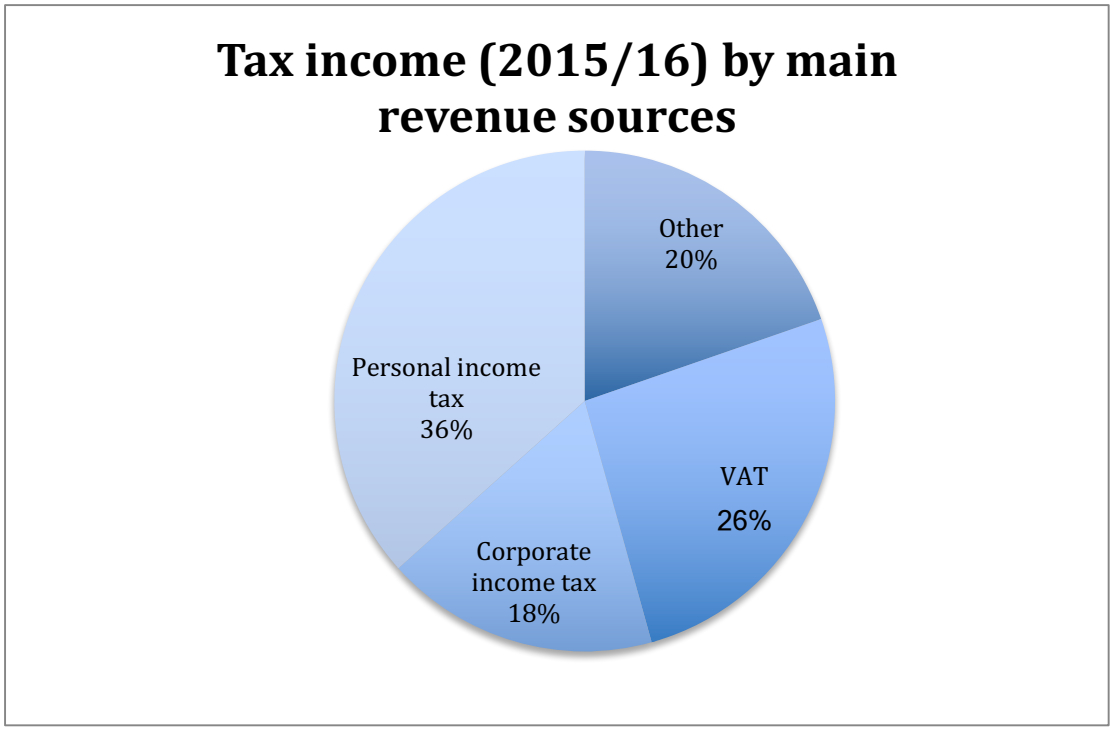
The shortfall in funding the NHI system will have to be financed from other revenue sources and/or government departments. When exploring which mix of funding sources to use, the most equitable, efficient and sustainable balance has to be found. The overall tax burden should remain reasonable so that is does not have a significant negative impact on economic growth, employment and investment. Further, the contribution structure should be progressive - it is meant to reflect social solidarity through both income and risk cross-subsidisation (Botha and Hendricks, 2008).

According to the NHI White Paper the main options for broadening national health funding in South Africa is through increasing direct tax (i.e. income), indirect tax (e.g. value-added tax), payroll taxes or premiums. An increase in direct tax, through a surcharge on taxable income could allow for a relatively high tax

threshold, similar to the Medicare Levy in Australia (BRON). While this might be the most promising option, it could have a negative impact on savings. A payroll tax, like the Unemployment Insurance Fund (UIF), would be imposed on the employed and/or the employee, but recent global trends show a movement away from this type of taxation. While funding from indirect taxes is less distortionary, it is not a realistic option, as indirect taxes are regressive in nature and it would defeat the purpose if the NHI by just burdening the poor proportionally more.

The consolidated South Africa tax revenue for all spheres of government (national, provincial and local government) was estimated to be 26.3% of GDP, or R 1 069 700 million in 2015/16 (SARS, 2016). This figure has been relatively consistent during recent years. If the final projected figure for the NHI, of 6.56% of GDP is compared to the current health budget of 4.1% (National Treasury, 2016), it implies that an additional 2.46% will have to be sourced from tax revenues. In other words, tax revenue would have to increase by more or less 10%, as illustrated below. The following figure gives a breakdown of total tax revenue by income sources.

Figure 2: Tax revenue in South Africa by main sources



Source: South African Revenue Services

To illustrate the magnitude of the extra revenue that would have to be raised to fund the NHI: if tax revenue as a total had to increase by 10%, this will require a 27.7% increase in personal income tax, a 55.56% increase in corporate income tax or a 38.46% increase in VAT. As these are extremely large numbers it must follow that this increased expenditure on health care will come at the cost of other functions that share in the national budget, such as education or housing. If enough additional funding cannot be collected, a very likely scenario, then money will have to be reallocated from other departments - something that will be strongly opposed by other departments and is not a desirable outcome.

The NHI White Paper explains that revenue will be sourced by making it mandatory for everyone that earn above a certain level of income to make a contribution to the NHI fund. The NHI White Paper uses Thailand and Mexico as examples of countries where attempts to transform health financing have been successful. With a much smaller percentage of the South African population contributing to direct tax, it is a poor comparison to make. The following table shows exactly how notably these countries differ from South Africa, especially in terms of the tax base and unemployment.

Table 3: Comparison of Mexico, Thailand, Brazil and South Africa

(2014)	Population (in million)	Tax payers (in million)	Tax base	Unemployment	GINI coefficient
Mexico	122.3	46.3	37.8%	4.75%	48.1
Thailand	68	20	29.4%	0.9%	39.3
Brazil	202	50.5	25%	6.8%	52.9
RSA	55	5.7	10.3%	25.4%	63.4

Source: Healthman, 2016.

Further investigation of how countries with UHC fund it, serves as good authority to recommend an appropriate funding model for South Africa. As already mentioned,

Australia's Medicare system is funded through general taxation. It should be noted that their experience with UHC is a good example of why we should be cautious of UHC in general - the increase in demand for public health services, which resulted in lengthy waiting periods and general public dissatisfaction, led to government changing its policies by providing Private Health Insurance Rebates to encourage the use of private health insurance (Boxall and Gillespie, 2013: 1934). The UK's National Health Service, Canada's National Health Service and the Netherlands' NHI system all work on a similar basis – these are funded by general taxation. Interestingly, these countries are also faced with the problem of demand exceeding supply.

France's NHI fund receives its contributions from employers and employees. The NHI in France, however, does not cover full health care expenditure - about 30% are co-payments, paid by individuals or by complementary private health insurance schemes. Germany has the oldest NHI system in the world. The Statutory Health Insurance plan is funded by a combination of employee contributions, employer contributions and government subsidies, with the option of opting out and using private insurance by paying a specific tax (Rodwin, 2003: 36). Spain and Belgium's UHC are also largely funded by contributions of employees and employers to sickness funds (Duran, et al, 2006: 20).

It is also useful to consider Columbia's social health system. In 2002 the WHO named it the fairest in the world in terms of financial contributions. It consists of two types of insurance: the Contributive Regime (CR), to which all tax-paying citizens contribute 12.5% of their salaries, with the employer paying 75% and the employee paying 25% of this tax, and the Subsidised Regime (SR) which covers the poor and is financed by general taxation and contributions from the CR. A means test is used to categorise the poor into six levels and health insurance is then subsidised for the people in the bottom two levels, with the other levels being eligible for subsidies only if funding is available (Hsiao and Shaw, 2007).

While the lessons from other countries are informative, South Africa will have to tailor a NHI to its own needs, given its small tax base, high burden of disease and high unemployment levels. A 'one size fits all' model simply will not work.

6 CONCLUSION

Given South Africa's poor growth outlook and its unique quadruple burden of disease, the NHI that is set out in both the Green and White papers seem unaffordable, certainly in the short run. Alternative models might be a social health insurance (SHI) system, which could be introduced as an intermediate step towards UHC. However, given that the current government is committed to a NHI and has already commenced with its implementation through pilot programs, it is probably prudent to do more work around cost scenarios and possible sources of funding. Based on the international experience in this regard, it would seem that a combination of direct taxes and payroll taxes might be the best option for funding of a NHI for South Africa. However, a gradual approach is recommended if this is to be achieved in the medium to longer term.

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