Financing NHI

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Introduction

- Potentially huge financial implications and major risks
- NT responsible for the management of government's finances, needs to plays a key role in planning and implementing this reform
- Health financing
  - Revenue raising
  - Pooling
  - Purchasing
  - Provision
- NHI a policy priority for government
- Fiscal environment
- Piloting
- Decisions

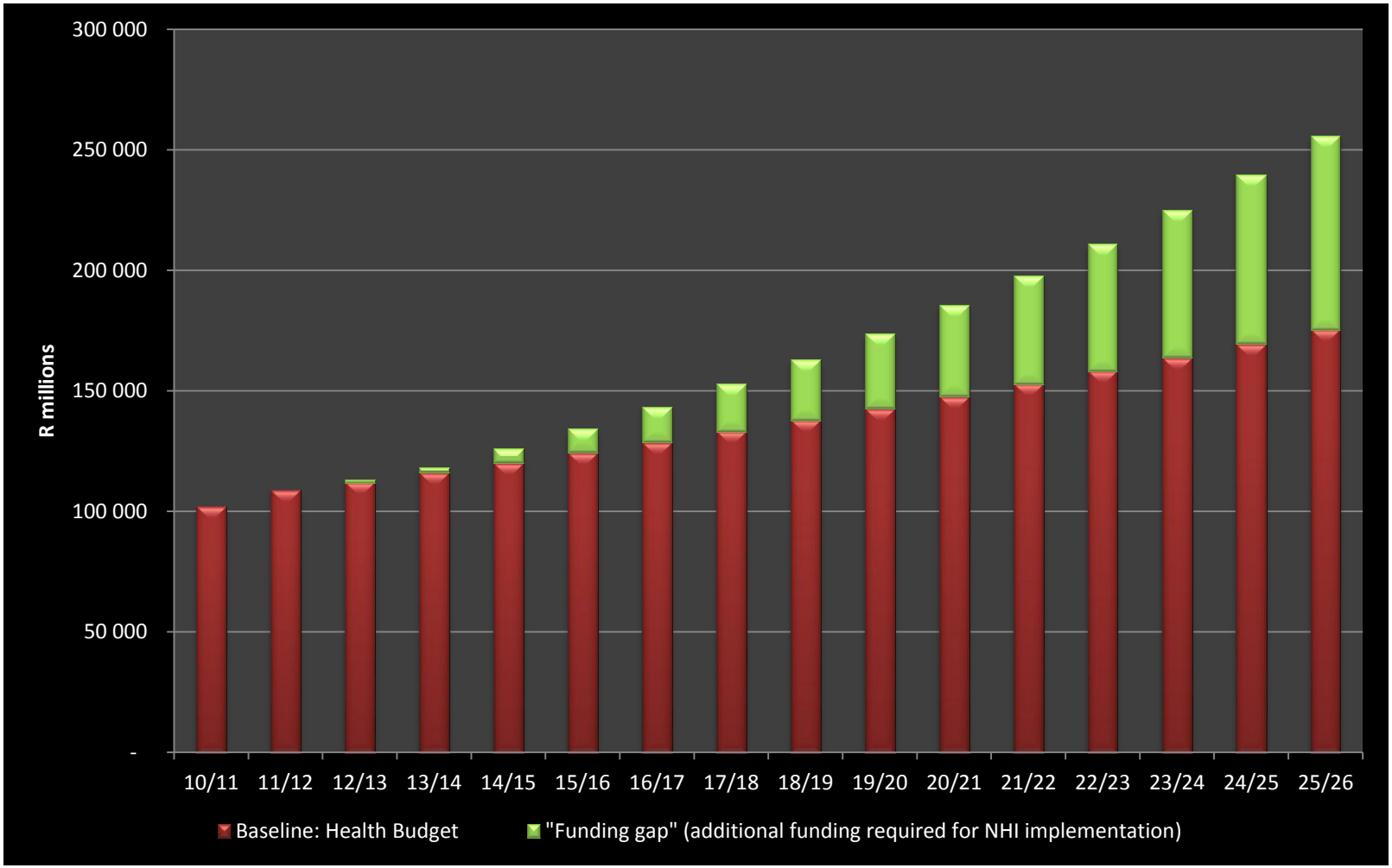
Costing

- Three costing models
  - HEU/PWC (utilisation and unit cost)
  - McCleod/Grobler (actuarial; costs per beneficiary by age group)
  - ASSA (actuarial)
- All three models had various scenarios and many assumptions
- But all had scenarios not far off the R255 billion cited in the White paper (10/11 prices) vs R100b-110b baseline

Spending projections

- Cost models showed an additional funding requirement of between R70-80 billion by 2025/26. Two further costing models show broadly similar results but the projections vary based on the assumptions such as:
  - Pace and phasing of reforms
  - Changing balance between public and private provision
  - Demographic changes: population structure and epidemiological profile
  - Medical inflation over long term: challenges predicting technological change
  - Utilisation: to what extent can this be influenced through PHC, shorter length of stay
  - Unit costs: extent to which private sector is used, wage inflation
  - Benefit package: what is included or excluded
  - Supply side constraints: limited over MT by practical input and capacity limits

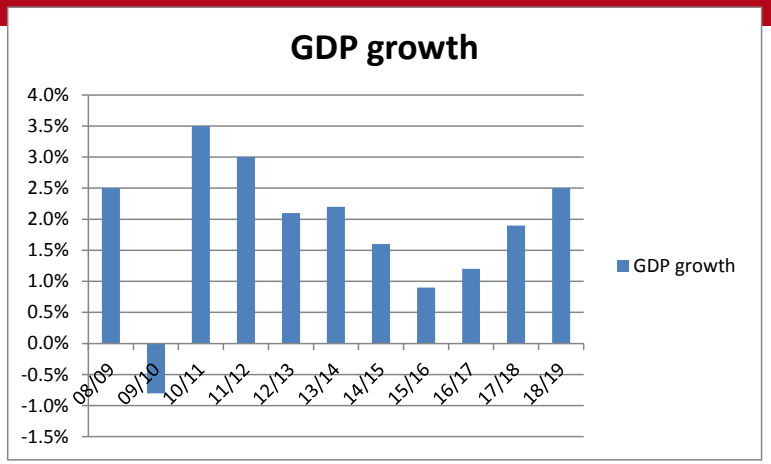
NHI: Funding Requirements

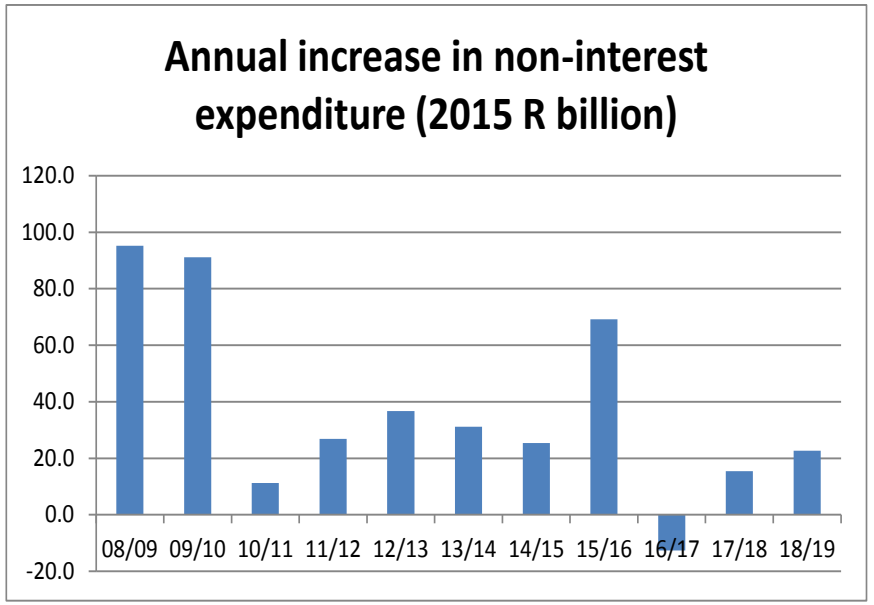


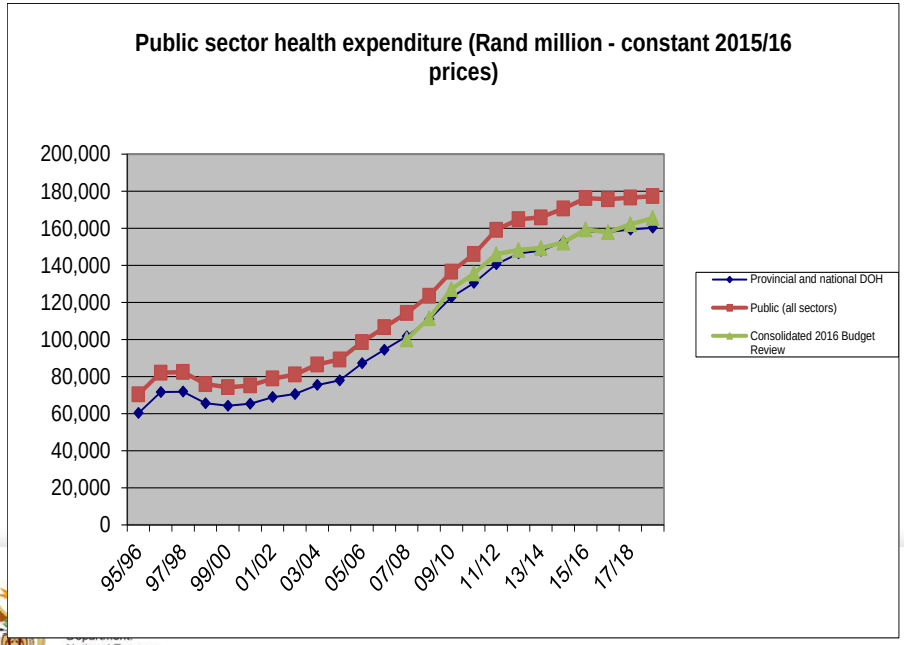
But we may need to revisit the costing

- **Utilisation assumptions not increasing at rate envisaged for both PHC and hospitals:** Even if policy changes implemented by 2025/26, cost increases seem likely now to take much longer e.g. slower changes in utilisation rates
- **Gap between actual MTEF and NHI costing numbers:**
  - Baseline funding increases slower given fiscal environment, so gap to be filled larger if costs not modified
  - Spending and funding assumptions not growing in the way anticipated in models (e.g. R163b in 18/19 (10/11 real prices) vs. R126b-R130b actual
  - Scale-up from R130b (real) in 18/19 to R255b in 2025/26 seems unlikely given spending changes to date
- **Shift out R255b in 2025/26:** Probably sensible to revise cost model and linked tax requirements

Fiscal constraints







How have other countries financed health care?

	Public Funds		Private Funds				
Countries	General government expenditure on health	Social security funds	Private health insurance	Out of pocket expenditure	Non-profit institutions serving households (eg, NGOs)	Other	Total
Australia	70.1%	0.0%	8.3%	19.0%		2.6%	100.0%
Brazil	45.7%	0.0%	22.4%	31.0%	0.9%	0.0%	100.0%
Canada	67.3%	1.4%	13.5%	15.5%		2.3%	100.0%
Chile	40.6%	6.8%	18.6%	34.0%	0.0%	0.0%	100.0%
China	16.9%	33.3%	3.1%	41.1%		5.6%	100.0%
Colombia	27.4%	56.1%	7.8%	7.8%	0.9%	0.0%	100.0%
Malaysia	44.4%	0.4%	8.0%	40.4%	0.3%	6.6%	100.0%
Mexico	21.9%	26.4%	4.0%	47.8%		0.0%	100.0%
Republic of Korea	11.5%	42.6%	4.3%	34.8%	0.7%	6.1%	100.0%
South Africa	**39.0%**	**1.2%**	**39.6%**	**17.7%**	**1.9%**	**0.6%**	**100.0%**
Thailand	70.0%	6.9%	5.9%	16.5%	0.4%	0.4%	100.0%
United Kingdom	83.6%	0.0%	1.1%	10.4%	3.8%	1.1%	100.0%

Source: National Health Accounts, WHO 2009, Geneva

Some country examples

- **Australia** (*Medicare*)
  - Mainly funded by general revenue (stable, efficient, equitable and low-cost means of finance)
  - Supplemented by GST, 1.5% Medicare Levy, 1% Medicare Surcharge Levy (without major equity compromises)

- **Ghana** (*National Health Insurance Service*)
  - NHIS is predominantly funded through a 2.5% contribution from VAT
  - This revenue is supplemented by a 2.5% payroll contribution from formal sector and a mix of registration fees and premiums.

There are a variety of direct and indirect taxes in South Africa

- **Direct Taxes** (income)
  - Personal Income Tax / Individuals
  - Corporate Income Tax
  - Dividend withholding tax (Previously Secondary Tax on Companies)
  - Estate Duty
  - Donations Tax
  - Payroll Taxes
    - Skills Development Levy
    - Unemployment Insurance Fund

- **Indirect Taxes** ("consumption")
  - Value Added Tax (VAT)
  - Excise Duties (Specific and Ad Valorem)
  - Custom Duties
  - Transfer Duties (Properties)
  - Security Transfer Tax (Financial transactions - shares)
  - Environmentally-related taxes
    - Fuel Levy
    - Electricity levy – non-renewable generation
    - Air Passenger Departure Tax
    - Plastic Bag Levy
    - Tax on incandescent light bulbs
    - CO_2 Motor vehicle CO_2 emissions tax

Potential funding for NHI

- Budget Review 2012:
  - *Over time, the new system [NHI] will require funding over and above current budget allocations to public health. Funding options include:*
    - *Increase in **VAT**;*
    - ***Payroll tax** on employers;*
    - ***Surcharge on taxable income**; or*
    - *A **combination** of the above.*
  - *Achieving an appropriate balance in the funding of national health insurance is necessary to ensure that the tax structure remains supportive of economic growth, job creation and savings.*

- The three tax instruments all have different consequences and careful thought needs to go into adjusting / introducing new mechanisms.

Tax options under consideration for NHI

Tax	Pros & cons
Surcharge on taxable income: • Personal Income Tax (PIT) system is progressive, marginal tax rates increase - 18% to 40%. • Allows for relatively high tax threshold	• A flat surcharge on taxable income in addition to the PIT liability (similar to the Medicare levy in Australia) could be considered • Administratively feasible • Possible concern is the potential negative impact on savings
Payroll Taxes: • Imposed on employer and/or employee • Current payroll taxes: UIF, Skills development levy (1%)	• Increases cost of employment and incentivizes movement to the informal economy • Consider high unemployment rate in South Africa • Recent global trends show a movement away from this due to the impact on cost of employment, esp. for low & unskilled workers
Value added tax: • Indirect tax • Levied on transactions	• Less distortionary, has a relatively broad base • All those benefitting from NHI would contribute in some way • Does not impact on savings or employment negatively • Impact on the poor – how regressive and how to compensate? • Most VAT revenues from middle and upper income households • SA's VAT rate 14% - compared to global average of 16.4% • Used to fund NHIS in Ghana (majority of funding – 2.5% levy), considering the tax base and future growth in Ghana

Cumulative required tax increases for a combination of payroll taxes, surcharge on taxable income & VAT

		Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Payroll tax and VAT increase	2015/16	0.5%		0.5%
	2018/19	1.0%		1.0%
	2021/22	1.5%		1.0%
	2022/23	1.5%		1.5%
	2024/25	2.0%		1.5%
	2025/26	**2.0%**		**1.5%**
Scenario B: Surcharge on taxable income	2015/16		1.0%	
	2017/18		1.5%	
	2019/20		2.0%	
	2021/22		2.5%	
	2022/23		3.0%	
	2024/25		3.5%	
	2025/26		**4.0%**	
Scenario C: Surcharge on taxable income and VAT increase	2015/16		0.5%	0.5%
	2018/19		1.0%	1.0%
	2021/22		1.5%	1.0%
	2022/23		1.5%	1.5%
	2024/25		2.0%	1.5%
	2025/26		**2.0%**	**1.5%**
Scenario D: Surcharge on taxable income, VAT increase and Payroll tax	2015/16	0.5%	0.5%	0.0%
	2016/17	0.5%	0.5%	0.5%
	2021/22	0.5%	1.0%	0.5%
	2022/23	1.0%	1.0%	0.5%
	2024/25	**1.0%**	**1.0%**	**1.0%**

Pooling: formation of NHI Fund

- Establishment of the NHI Fund: fairly straight forward as Schedule 3A public entity
- Could be formed initially building on several conditional grants that fund personal health services e.g. NTSG grant (R14b), HIV and TB grant (R20b), indirect NHI grant, new ideal clinic component and new funds
- Organisation and governance of the NHI Fund
- Could be introduced within 3 years
- This is the easy part

Pooling: inter-governmental location of functions and funding

- This is the more difficult part
- Reviewing powers and functions across spheres of government (funds follow function)
- **Five main options:**
  - Function shift – centralisation e.g. central hospitals
  - Shared functions e.g. PHC (NHI as a supplementary funding stream over and above PES)
  - Centralisation and delegation
  - Provincial funds
  - Constitutional change
- These options have huge implications
- Until this is settled and with provinces, difficult to move on several other issues

Purchasing

- **<u>Key set of issues for NHI systems:</u>**
  - Separation of purchaser from provider
  - Reimbursement reform: DRGs, capitation
  - Contracting: information systems
  - Contracting with public and private providers
  - Pricing of services to bring in a diverse mix of public and private providers
- Very little piloting of purchasing reforms to date in pilot sites. This is a problem because purchasing reform is central to NHI and we have little sense of unit costs, what kind of contracts will work, etc. Would like to see more attention on these areas

Provision

- Necessary to get clearer sense of future envisaged mix of public and private providers and how this will be rolled out
- Current contracting of GPs in pilot sites is a sessional employment model, not an independent practice model as in most NHI systems
- To raise specific new taxes for NHI, users need to understand and value improved services and benefits they will be receiving
  - Strengthening public health services
  - Improving quality and accreditation

Summary

- NHI will necessitate **additional public funding** to the national health budget – could reach R72.0 billion rand in real (2010/11) terms by 2025/26, but significant time has elapsed since previous costing and probably need to revise
- Focus on **better health care outcomes** and **management** of the health care system (**value for money**) very important
- **Uncertainties around costs** need to be refined through piloting new purchasing models
- **Three main revenue options** outlined - surcharge on taxable income / higher personal income tax rates, VAT & payroll tax
- Establishment of **NHI Fund**. Critical aspects and legal considerations
- Way forward on **intergovernmental functions** and linked funding is critical to resolve
- **Active purchasing** including contracting is critical and **capacity** must be built up at district, provincial and national level
- Design of **benefit package** requires further work
- **Mixed public and private provision** - careful piloting of purchasing. Patient choice likely to be important in acceptability of new taxes
- NHI is a long-term path and its success is contingent on proper planning including **cost containment** measures to ensure financial sustainability
- NHI workstreams discussing practical application