Health financing and NHI in South Africa: why do we need a reform?

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Outline

• What is health financing?

• South African health system in brief

• Why do we need the NHI?
  – Inequality and inequity in health and health care in South Africa
  – Impact of medical scheme membership
    • Affordable?

• Overview of the NHI
  – Beyond health financing...
What is health financing?

• Revenue collection
  – the way health systems raise money from households, businesses, and external sources

• Pooling risks
  – the accumulation and management of revenues in a way as to avoid large, unpredictable health expenditures

• Purchasing goods and services
  – the mechanisms used to secure services from public and private providers
History: the SA health system...

• Apartheid era (1948 – 1994)
  – Fragmented health system
    • Different health department and administration for different population groups
      – 14 separate health departments
    • Separate public health facilities for the blacks and the whites
    • Health services for the black majority were heavily underfunded
    • Rural areas and ‘homelands’ were neglected
  – High levels of inequalities and inequities
    • ...the vulnerable population groups bearing a heavy burden

• Post apartheid (1994 – )
  – Formal constitution adopted in 1996
  – One national and nine provincial health departments
    • A decentralised system
  – Public health sector restructuring
    • Considerable importance attached to PHC
  – Formal moves to address issues for the vulnerable (and in fact for all South African residents)
  – Commission of Inquiry for a NHI Fund/system
South Africa: the health system...

- **Current outcome: a tiered system**
  
  - **Public sector**
    - Funded largely through general tax revenue
    - Over 80% of the population *totally* dependent on the sector
    - Three tier public hospital structure (tertiary, regional, and district) + primary health care system
    - Accounts for about 40% of total health care expenditure
    - <50% of both financial and human resources
  
  - **Private sector**
    - Financed largely through private medical scheme (i.e., private health insurance)
    - Serves (mainly) less than 20% of the population with private health insurance
    - Comprises a range of providers – GP, specialists, pharmacies, private hospitals, etc.
    - Accounts for about 60% of total health care expenditure
    - >50% of both financial and human resources

- **Over 8% of GDP → health services**
  
  - One of the highest globally
Since 1994, public health-sector resourcing has been fairly stagnant

Expenditure in the private sector has increased substantially

Per capita private health expenditure is ~6 times per capita public health expenditure

Inequality in health in South Africa

The diagram illustrates the distribution of various health issues among the population. The x-axis represents different types of illness and disability, while the y-axis shows the age/sex standardised concentration index. The data indicates that certain health issues, such as TB, HIV, and diabetes, are more prevalent among the poor, whereas others, like physical and hearing impairments, are more common among the rich.

Comparing health benefits and need across SES

- Poor need more health services
- Rich benefit more than the poor
- Inverse care law

Source: Ataguba & McIntyre (2013): Health Economics, Policy and Law - http://dx.doi.org/10.1017/S1744133112000060
Medical scheme membership and OOP payments (2008)

• Scheme members have significantly higher private facility visits than non-scheme members

• Scheme members pay more out-of-pocket (OOP) than non-scheme members

→ Medical scheme membership has not been able to guarantee access to needed health services at affordable costs to members.

The proposed National Health Insurance

**Phase 1**
- [5 years]
- Creating a condition for efficient and equitable delivery of quality services
  - PHC re-engineering
  - Transforming the structure and financing of central hospitals
  - Improving quality of health service delivered, address infrastructure deficiencies, availability of essential medicines, etc.
  - Improving management deficiencies

**Phase 2**
- [5 years]
- Ensuring an efficient purchaser-provider split and establishing a NHI fund (transitional)
  - Funded largely through general taxes
  - Registering the population (prioritising the vulnerable)
  - Strengthening contracting of private providers (primary level)
  - Amending the medical schemes act (??)

**Phase 3**
- [4 years]
- Consolidating on the previous phases and address issues of accreditation of private providers
  - Fully functional NHIF
  - Introducing mandatory prepayment from those that are eligible
  - Contracting of private providers (higher levels)
Main features of the NHI

Universal access

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment
- Comprehensive services

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment
- Comprehensive services
- Financial risk protection

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment
- Comprehensive services
- Single fund
- Financial risk protection

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment
- Comprehensive services
- Single fund
- Financial risk protection

Source: NHI White Paper
Main features of the NHI

- Universal access
- Mandatory prepayment
- Single payer
- Strategic purchaser
- Single fund
- Comprehensive services
- Financial risk protection

Source: NHI White Paper
Moving towards NHI...

NHIF = single fund = single payer = single purchaser
The proposed National Health Insurance

• “Concerns” for the NHI
  – Public sector ill-equipped and unprepared
  – Resources constraints
    • Financial sustainability (affordability)
    • Human resource shortage
  – The importance of the SDH
  – Opposition from certain groups/ stakeholders
Long-term impact (benefits) of NHI modelled

- Status quo and extended medical scheme models perpetuates inequities
- ‘NHI-type’ model gives a more ‘equitable’ distribution

Table 3: Kakwani indices for different health care financing options

<table>
<thead>
<tr>
<th></th>
<th>Status quo</th>
<th>Extended private schemes</th>
<th>Universal coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General taxes</td>
<td></td>
<td></td>
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<tr>
<td>General taxes</td>
<td>0.022</td>
<td>0.022</td>
<td>0.022</td>
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<tr>
<td></td>
<td>(0.090)</td>
<td>(0.090)</td>
<td>(0.090)</td>
</tr>
<tr>
<td>Insurance</td>
<td>0.121**</td>
<td>0.033</td>
<td>0.198***</td>
</tr>
<tr>
<td></td>
<td>(0.061)</td>
<td>(0.066)</td>
<td>(0.067)</td>
</tr>
<tr>
<td>Out-of-pocket payment</td>
<td>-0.058</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.061)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income surcharge</td>
<td>-</td>
<td>-</td>
<td>0.115***</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.036)</td>
</tr>
<tr>
<td>VAT-levy</td>
<td>-</td>
<td>-</td>
<td>-0.144*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.075)</td>
</tr>
<tr>
<td>Overall</td>
<td>0.078</td>
<td>0.031</td>
<td>0.040</td>
</tr>
<tr>
<td></td>
<td>(0.063)</td>
<td>(0.067)</td>
<td>(0.074)</td>
</tr>
</tbody>
</table>

Notes: Robust standard errors in parenthesis.
(a) A 3% VAT rate; (b) a flat 4% income surcharge rate was used; (c) a graduated (1.2% - 6%) income surcharge rate was used.
*, **, *** significant at 10%, 5% and 1% levels of significance respectively.

Source: McIntyre & Ataguba (2012): Health Policy and Planning - [http://dx.doi.org/10.1093/heapol/czs003](http://dx.doi.org/10.1093/heapol/czs003)

• Marginally more equitable financing with ‘NHI-type’ model
Thank you