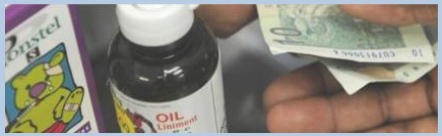


Health financing and NHI in South Africa: why do we need a reform?

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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

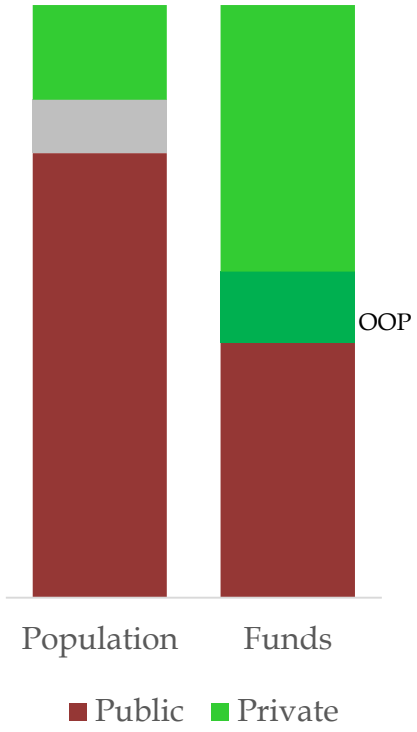
History: the SA health system…

- 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

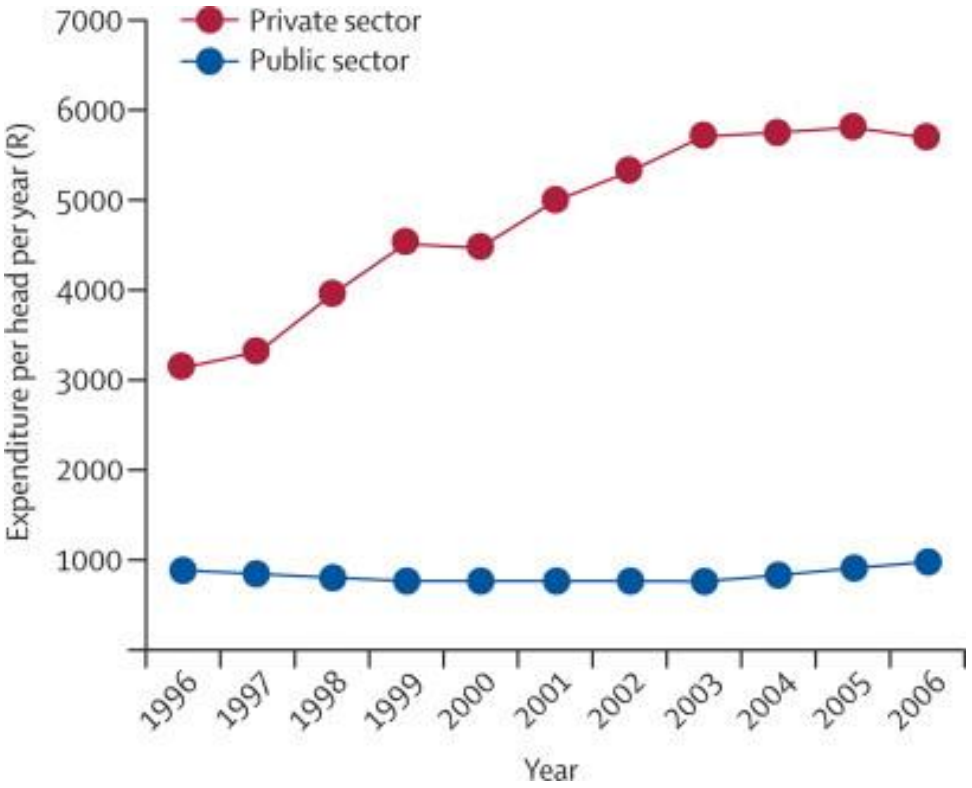
- Post apartheid (1994 –)
  - Formal constitution adopted in 1996
  - One national and nine provincial health departments
    - A decentralised system
  - Public health sector restructuring
    - Considerable importance attached to PHC
  - Formal moves to address issues for the vulnerable (and in fact 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



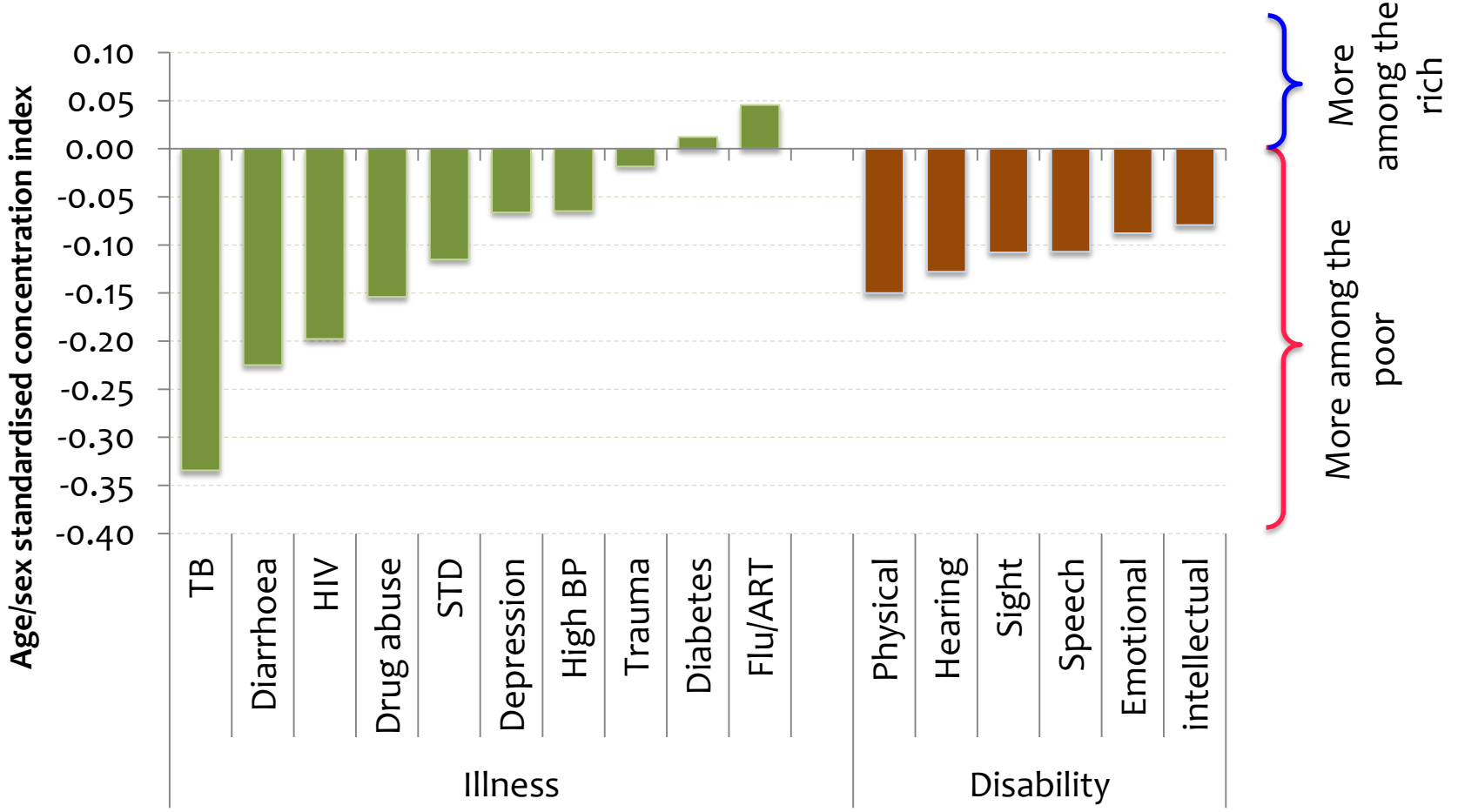
Health expenditure in South Africa



- 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

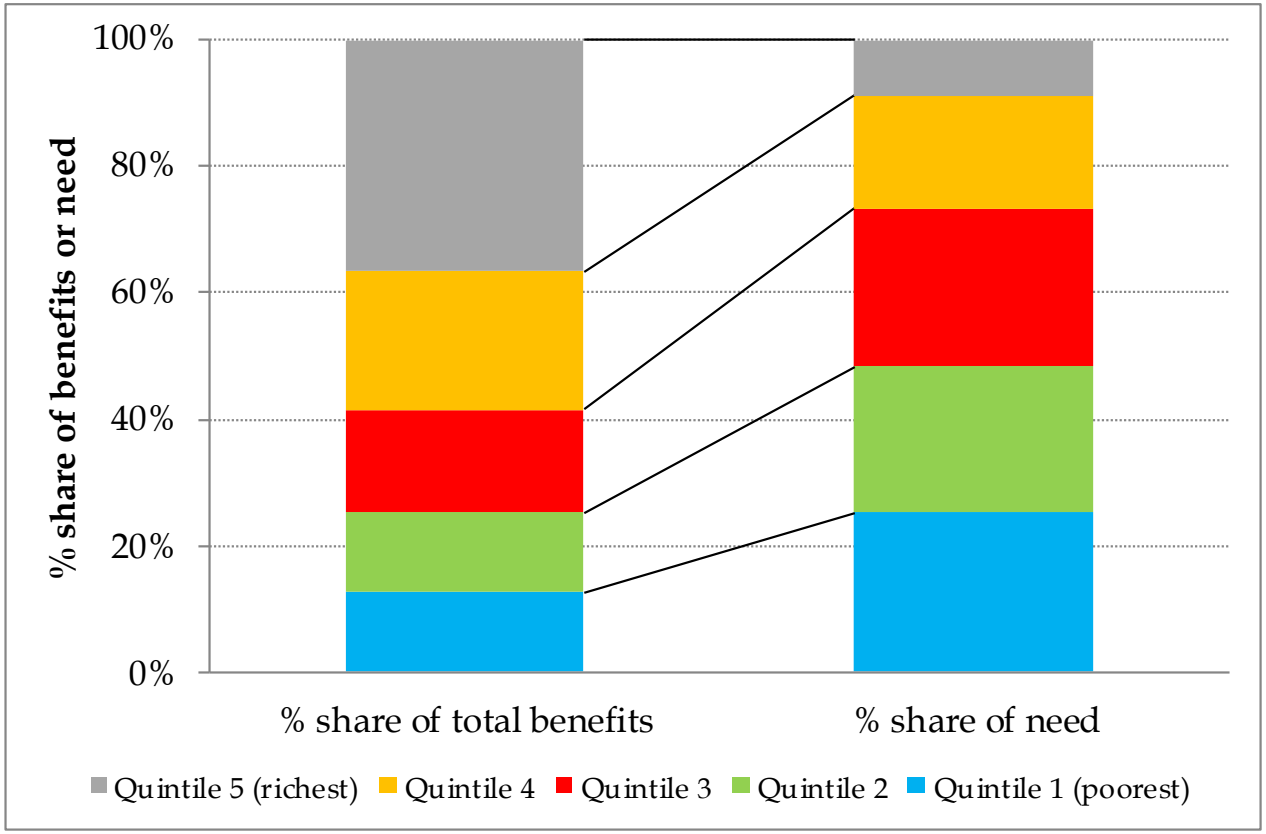
Source: Coovadia *et al.* (2009): *The Lancet* - http://dx.doi.org/10.1016/S0140-6736(09)60951-X

Inequality in health in South Africa



Source: Ataguba *et al.* (2011): *International Journal for Equity in Health* - http://dx.doi.org/10.1186/1475-9276-10-48

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.

Source: Ataguba & Goudge (2012): *The Geneva Papers on Risk and Insurance* - http://dx.doi.org/10.1057/gpp.2012.35

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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*)

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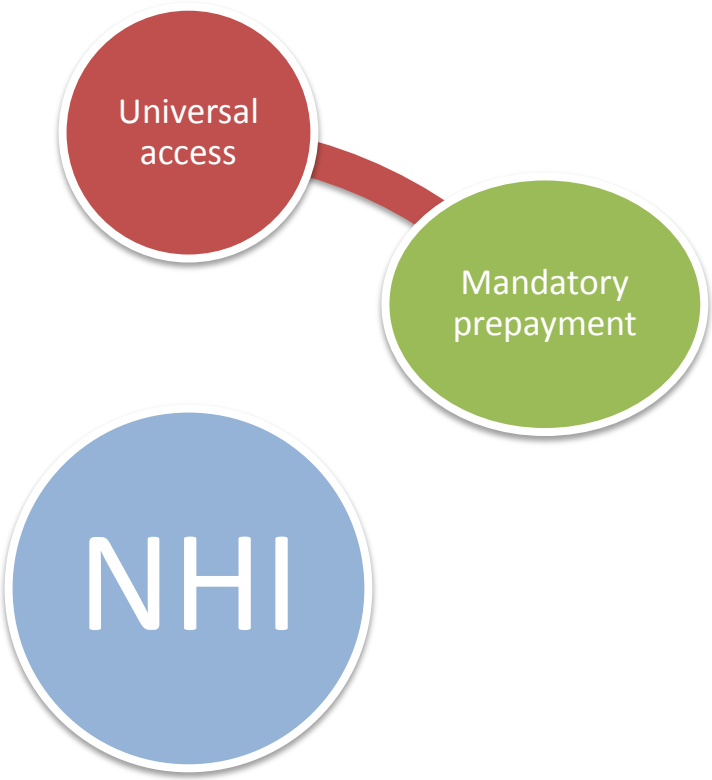
Main features of the NHI

Source: NHI White Paper

Main features of the NHI



Source: NHI White Paper

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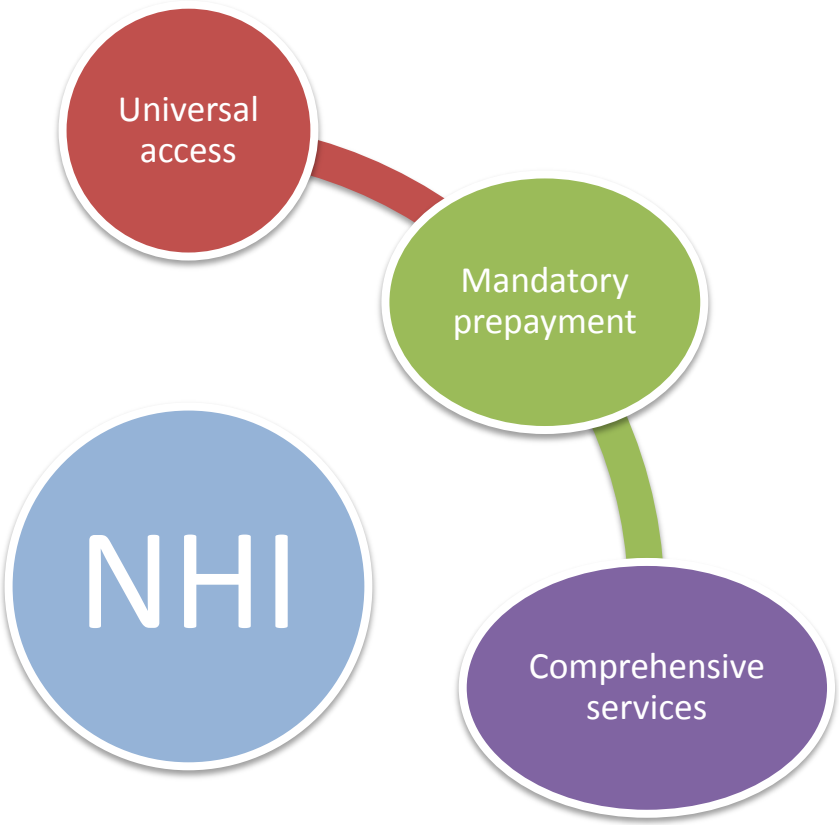

Source: NHI White Paper

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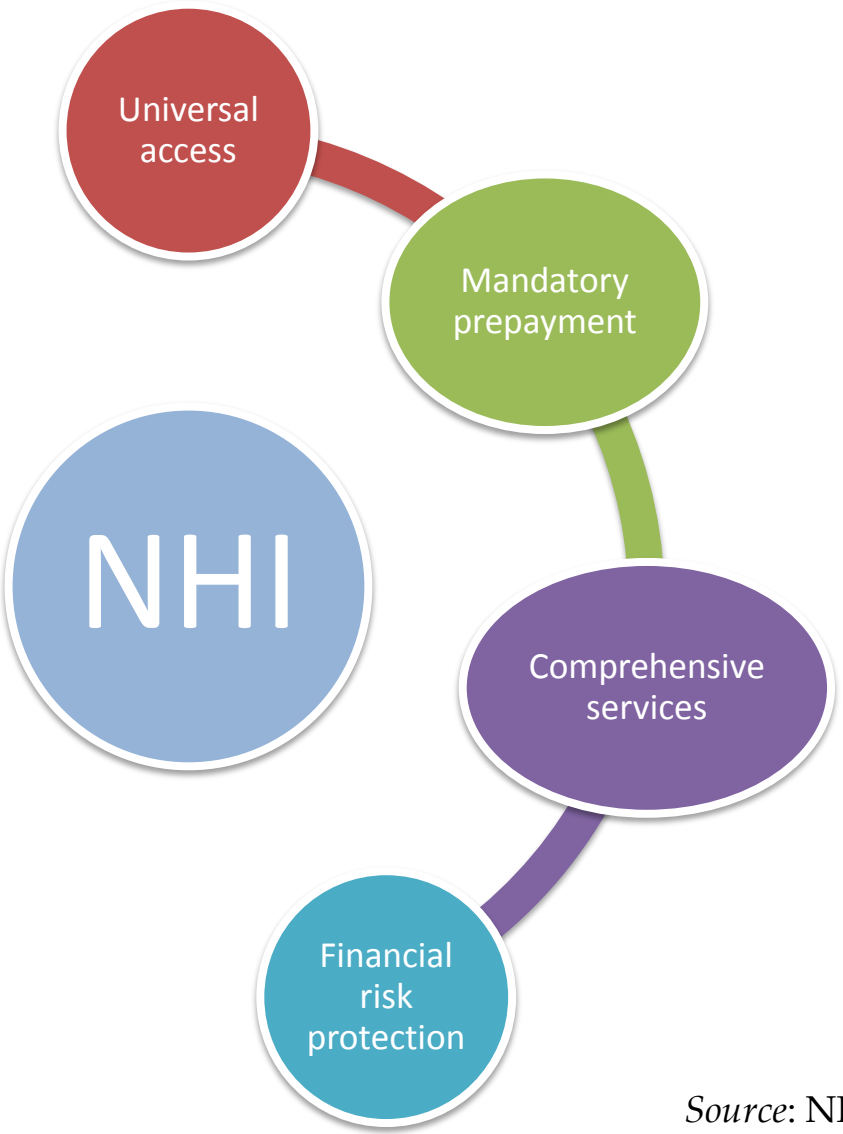

Source: NHI White Paper

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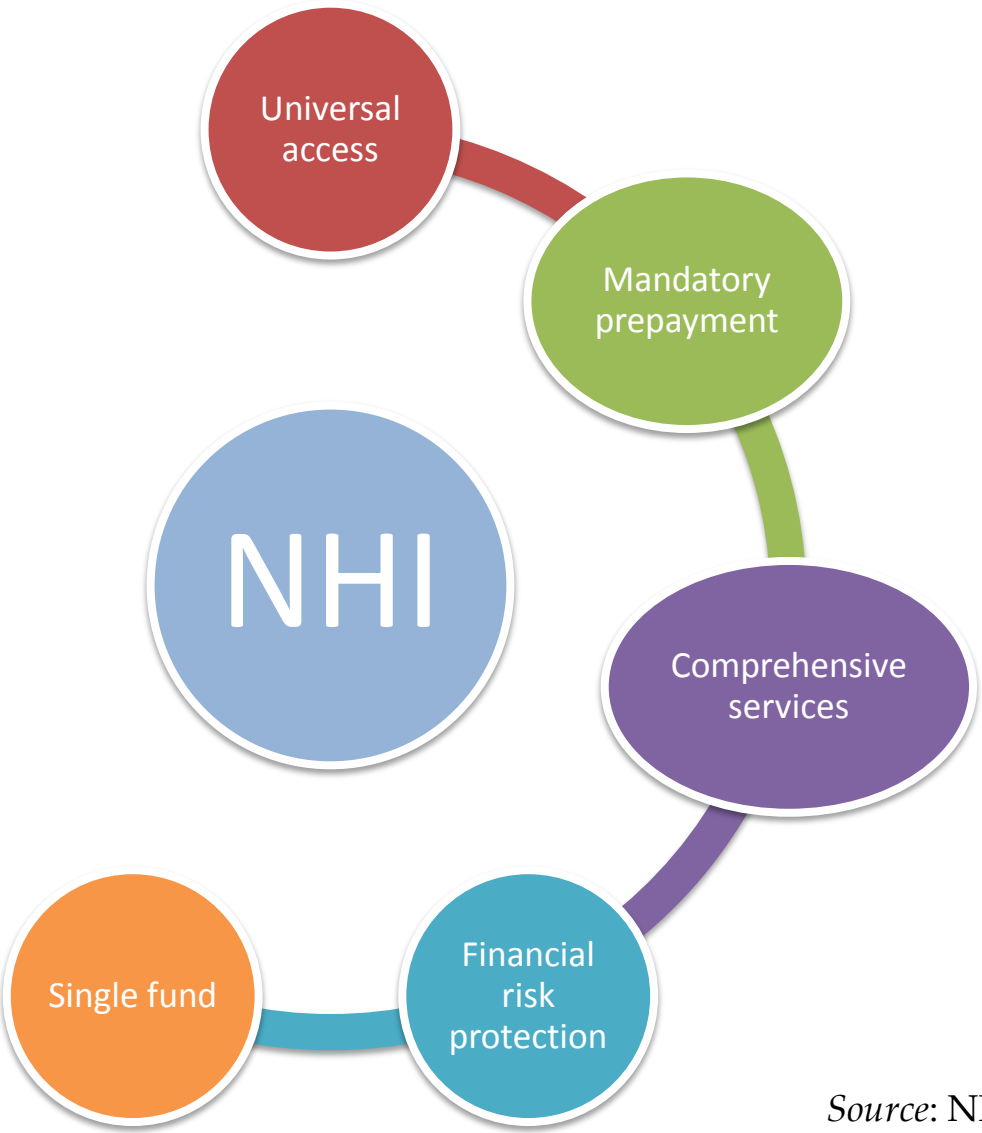

Source: NHI White Paper

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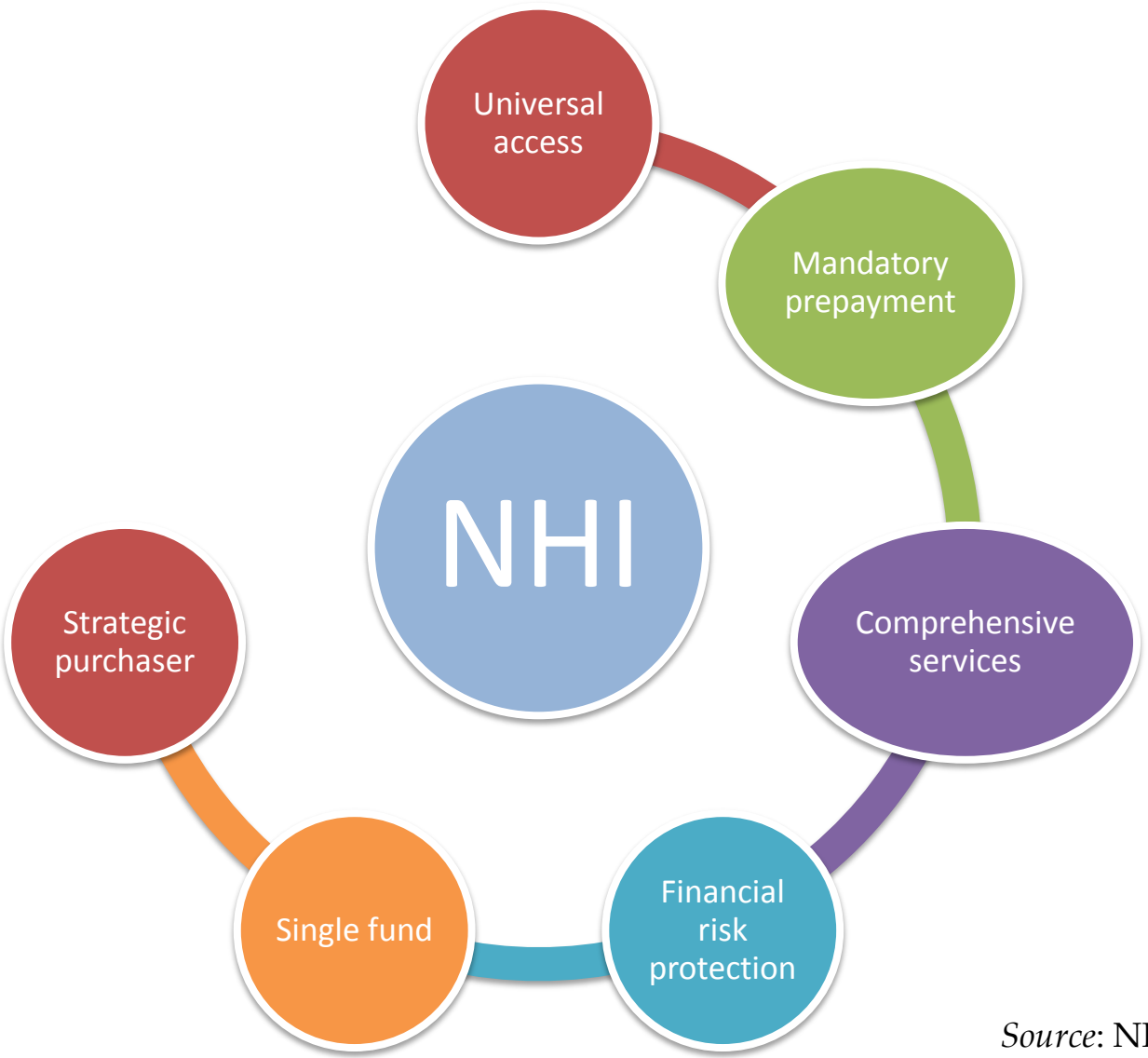

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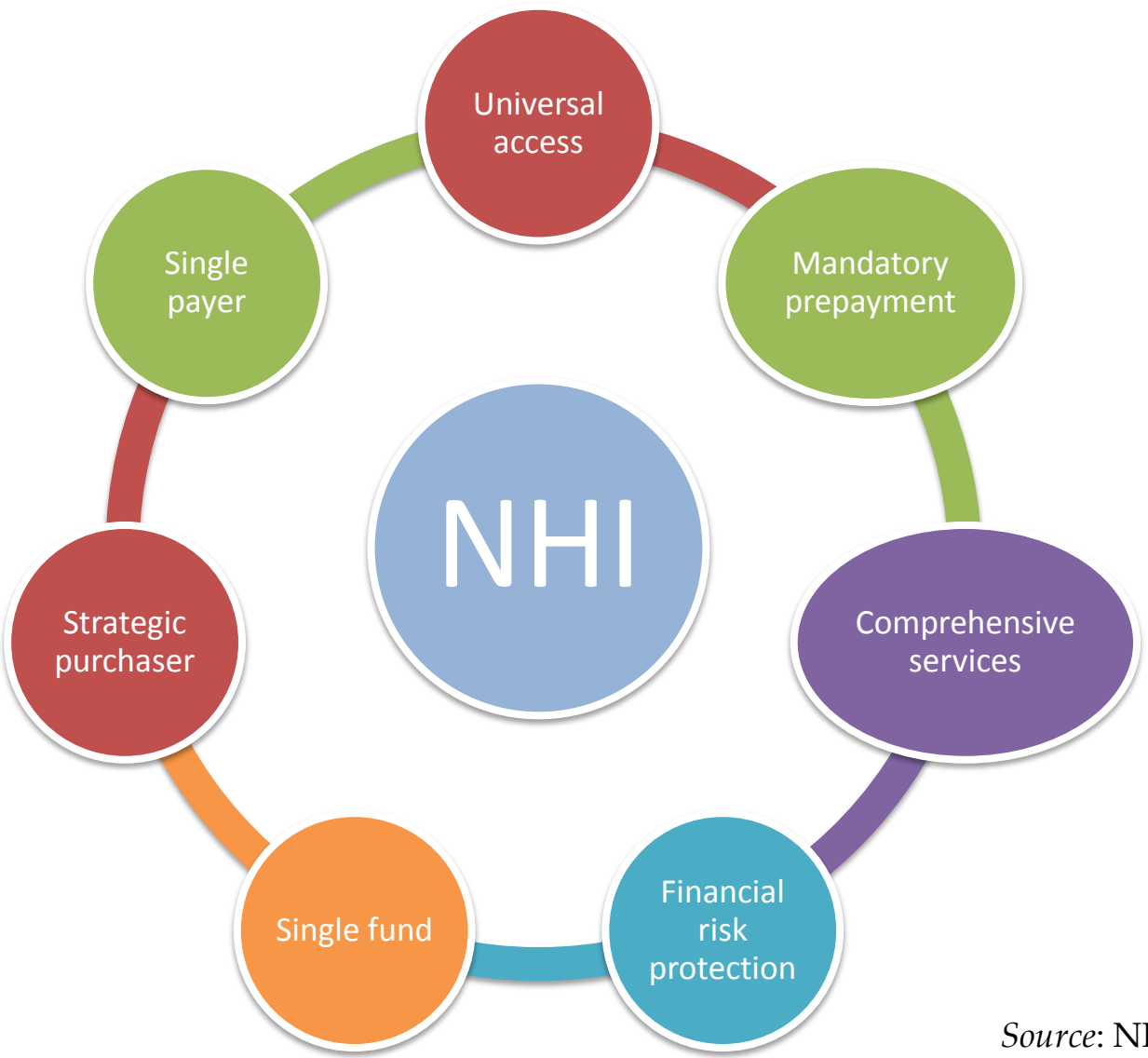
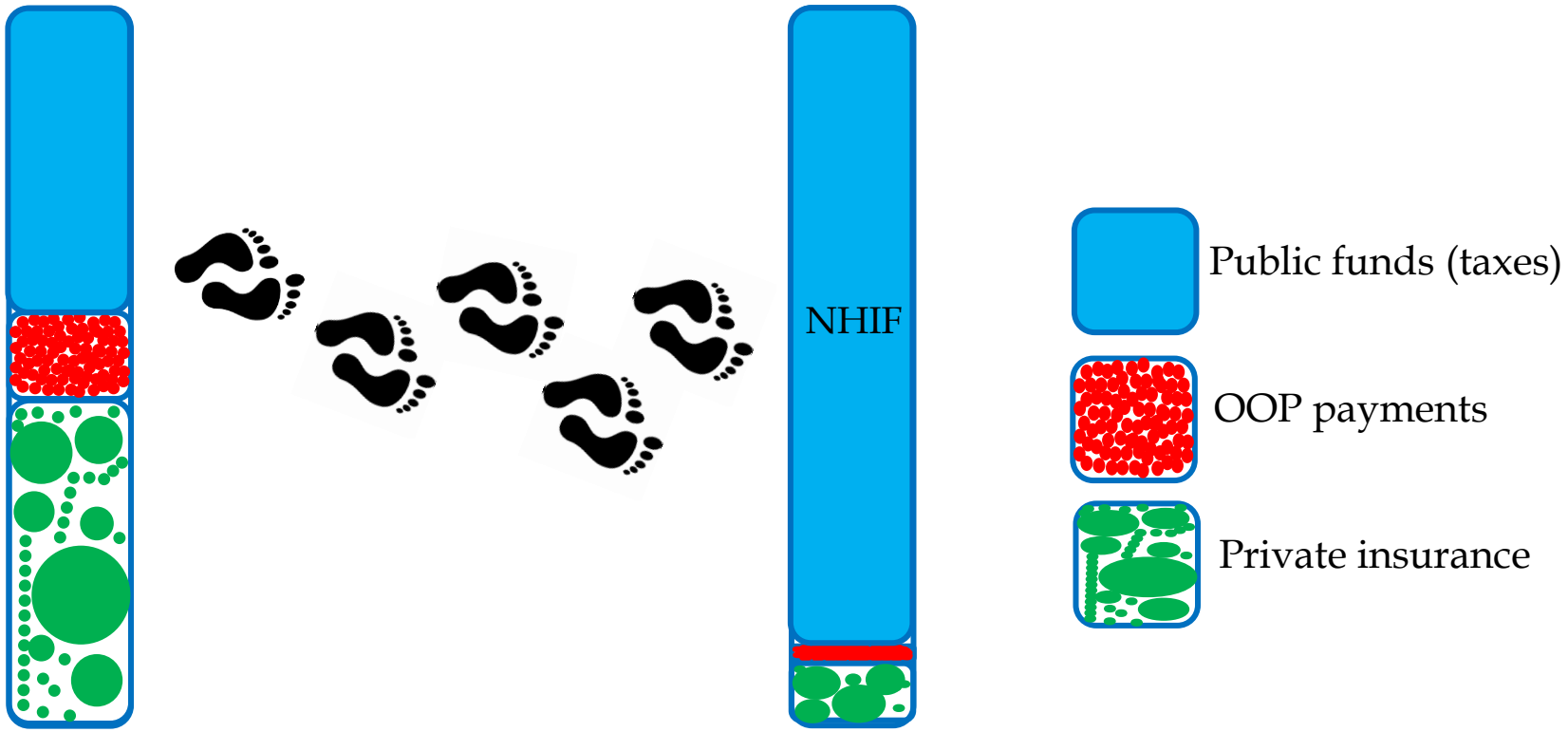


Source: NHI White Paper

Moving towards NHI…



NHIF = single fund = single payer = single purchaser

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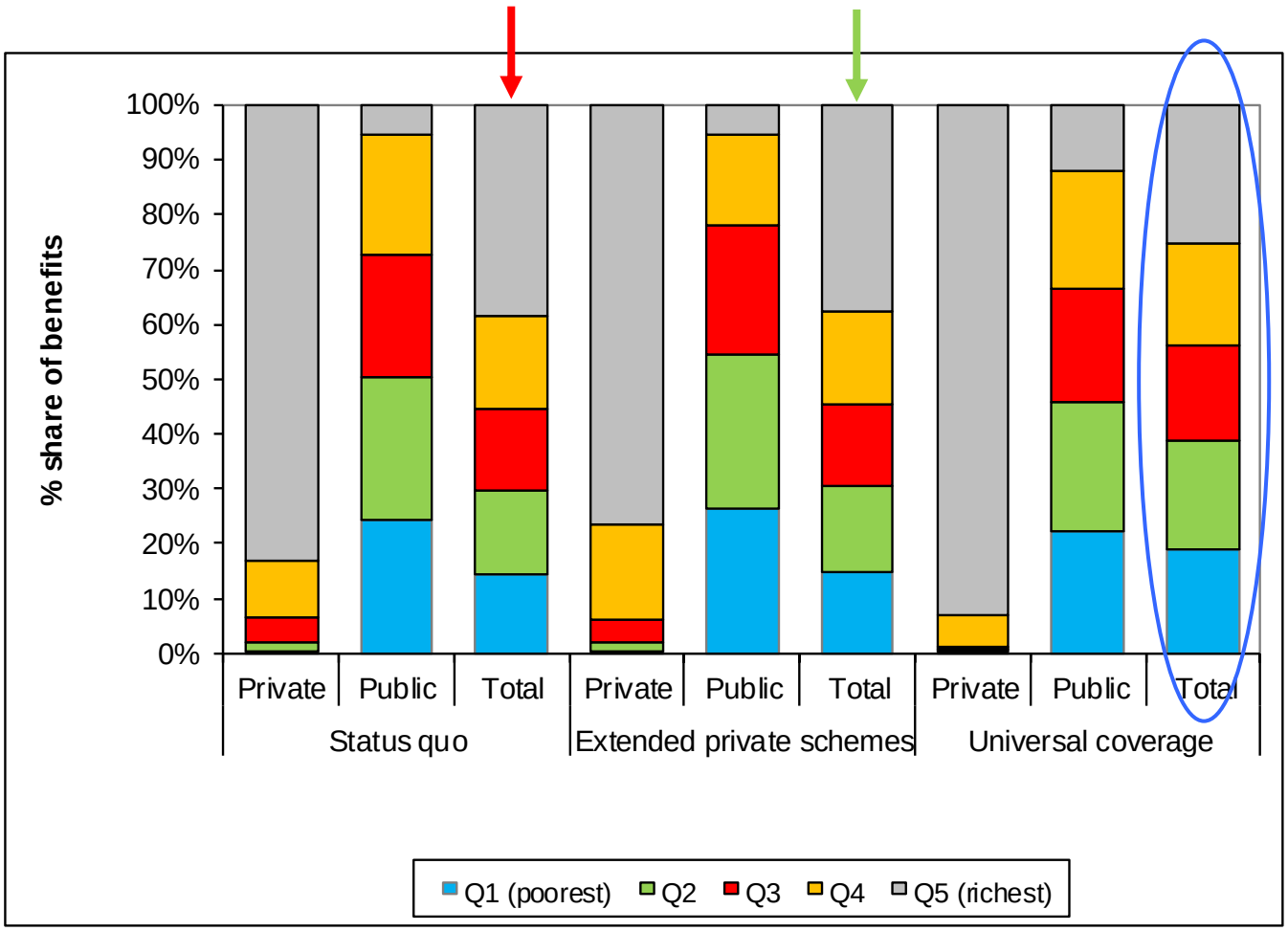
The proposed National Health Insurance

- "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

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

Long-term impact (financing) of NHI modelled

Table 3: Kakwani indices for different health care financing options

	Status quo	Extended private schemes	Universal coverage (a)	(b)	(c)
General taxes	0.022 (0.090)	0.022 (0.090)	0.022 (0.090)	0.022 (0.090)	0.022 (0.090)
Insurance	0.121** (0.061)	0.033 (0.066)	0.198*** (0.067)	0.198*** (0.067)	0.198*** (0.067)
Out-of-pocket payment	-0.058 (0.061)	-	-	-	-
Income surcharge	-	-	-	0.115*** (0.036)	0.198*** (0.048)
VAT-levy	-	-	-0.144* (0.075)	-	-
Overall	**0.078** **(0.063)**	**0.031** **(0.067)**	**0.040** **(0.074)**	**0.085** **(0.068)**	**0.100** **(0.067)**

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.

- Marginally more equitable financing with 'NHI-type' model

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

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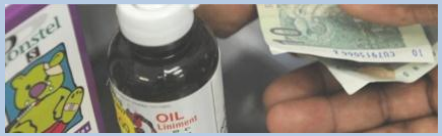
Thank you



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