The feasibility of National Health Insurance in South Africa and its anticipated additional burden on the country's tax base.

THE DEPARTMENT OF ACCOUNTING

RHODES UNIVERSITY

RESEARCH PAPER SUBMIITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DIPLOMA

OF

POSTGRADUATE DIPLOMA IN TAXATION

BY

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DATE OF SUBMISSION: NOVEMBER 2011

Abstract

This paper aimed to investigate the feasibility of the implementation of the proposed National Health Insurance. A further goal was to gauge the taxation implications that the implementation would have. The primary method of collecting information for this paper was through an extensive analysis of the available literature with regard to the debate surrounding NHI in South Africa. A key document in this process was the Green Paper released by the Department of Health on 05 August 2011 entitled "National Health Insurance in South Africa". Also, the work of health economist, Diane McIntyre, was frequently referred to. Prior to an analysis of the feasibility of the proposal, the present paper first provides a description of the current challenges faced by the health sector in South Africa and the roots of these problems. The paper also presents a brief history of health reform in the country and outlines the key objectives of the proposed NHI. An explanation of appropriate health care financing principles is also offered. It is important to research the feasibility of health reform in South Africa because there is an obvious need for drastic changes in the provision of health care in the country. The final recommendation of the present paper is to not implement the NHI proposal in its current form because it is not a feasible option given the limited fiscal resources in South Africa.

Keywords:

health reform; National Health Insurance; health economics; feasibility; taxation;

Acknowledgements

- I would like to thank Professor Stack for her endless guidance and supervision throughout the year
- I would like to thank my family who have made countless sacrifices in getting me to this point
- Finally, I would like to thank my friends for their constant support

Table of contents

Chapter One: Introduction

1.1 The need for change in the South African health care system

The African National Congress (ANC) is in the process of implementing a National Health Insurance (NHI) which promises to ensure "the realisation of the right to health care for all" (African National Congress: 2010).

Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) express the view that the current South African health care system is in dire need of transformation and is riddled with multifaceted challenges. Public spending on health care is unable to keep up with inflation and population growth and is put under tremendous strain by the HIV/AIDS and tuberculosis (TB) epidemics (Econex: 2009).

The main concern of the ANC is that there is a disparity of resources in the public and private health sectors in relation to the size of the population each serves (ANC: 2010). According to Grant Thornton (2010), around 5% of GDP is spent on providing private health care for 7 million people, while only 3.5% caters for the remaining 43 million South Africans. Ataguba and McIntyre (2009) confirm that the "bottom line" is that "benefits from health care are not distributed according to the need for health care".

The ANC (2010) have stated that the most significant challenge in the provision of health care services is a lack of trained personnel. They also point out that due to cuts in the provincial budgets and the closure of nursing colleges, fewer nurses are being trained. Breier (2010) draws attention to the alarming fact that an estimated 67% of nurses trained in the period 1997 to 2005 are not registered with the South African Nursing Council and have left the country to receive higher salaries in countries such as Saudi Arabia, Oman, the United Kingdom, the United States of America, Canada and Australia.

It is no surprise that South African trained doctors also choose to work overseas. According to Breier (2010), doctors prefer to be employed in developed countries where there is less crime, better public education, improved pay, and better working conditions in public hospitals. This type of skills flight damages the South African economy as it costs the country a staggering R780 000 to train one doctor (Breier: 2010).

The following statistics demonstrate the lack of staffing in the public health sector. In each case below the statistic shows how many more people each public servant professional has to serve in relation to the private sector (Health Systems Trust: 2006).

- Pharmacist: up to 30 times
- General doctor: up to 17 times
- Nurse: up to 6 times
- Specialist doctor: up to 23 times.

A further challenge for the public health sector is the shortage of drugs and the difficulty in making them easily available to the public (ANC: 2010). In contrast, the private sector actually has an oversupply of pharmacists, which is evident from the number of pharmacies located in close proximity to one another in urban areas (ANC: 2010).

Also, whilst the number of private hospitals and clinics continues to grow, the availability of hospital beds in the public sector has declined (ANC: 2010). With overcrowding taking place in state hospitals, the bed occupancy rate in the private sectors is only 65% (ANC: 2010). There is more than twice as many hospital beds per beneficiary of private hospital services as there are for those dependent on the services of the public health system (Health Systems Trust: 2006).

According to the ANC, in order to address these imbalances in access and utilisation of health services, the health care system in South Africa requires a fundamental revamp through the introduction of NHI (ANC: 2010).

The NHI will have to be funded through tax increases (Grant Thornton: 2010). There are three possible areas of taxation from which these funds could be collected:

- Personal Income Tax
- Value-added Tax
- Companies Tax.

According to the South African Revenue Service (2010), there are approximately 5.9 million individual taxpayers in South Africa. The Republic of South Africa currently has an estimated population of 49 million people (Central Intelligence Agency: 2011). This translates to a statistic which indicates that only 12% of the South African population pays personal income tax. This can be compared to the case of the United Kingdom which has a

population of 62.7 million (CIA: 2011). The United Kingdom has approximately 30.5 million individual taxpayers, meaning that 48% of their population pays personal income tax (HM Revenue & Customs: 2011). It is thus evident that a relatively small percentage of the South African population is carrying the burden of tax for a large majority.

Furthermore, only 2.75 million individual taxpayers cover 60% of the total tax burden in South Africa (Grant Thornton: 2010). It is important to note that this total tax burden includes all forms of taxation and not only personal income tax. This means that 60% of the total tax burden is being carried by less than 6% of the South African population.

It is suggested that putting additional strain on this small tax base and increased political uncertainty will encourage a skills flight (Grant Thornton: 2010). It is possible that in the short-term the top marginal tax rate could increase to 45% and if the required funding for the NHI is to be obtained by 2025, the effective tax rate for this same group could be as high as 55% (Grant Thornton: 2010). The country's economy is most reliant on the individuals in this taxpayer group and it is of great concern that these people will choose to relocate to other countries should they be faced with higher tax rates (Grant Thornton: 2010). It should be noted that the average top marginal tax rate globally is around 29% (Grant Thornton: 2010).

It is also expected that there would be great resistance to an increased Value-Added Tax (VAT) rate. Although increasing the rate of VAT on luxury goods and broadening the range of zero-rated goods could be an effective long-term solution as it spreads the tax burden across a far wider spectrum of the population, it is anticipated that the trade unions would offer stiff resistance to the idea (Grant Thornton: 2010).

Increasing the current company tax rate from 28% is likely to discourage foreign investment as investors choose to place their assets in countries with lower tax rates (Grant Thornton: 2010). It would thus appear that increasing this form of taxation is also not a truly viable option.

There is no doubt that there is a need for change in the provision of health care in South Africa. It is, however, important to research the feasibility and practicality of implementing NHI in South Africa in order to assess the impact on the country's financial resources. It needs to be determined whether or not an economy such as South Africa's is ready for what is widely considered to be a developed economy's solution to health care provision. It is important to research the implications of the increased burden on the country's relatively

small tax base in order to assess the sustainability of the available resources needed to fund the NHI.

1.2 Goals of research

The purpose of this research paper was:

- To investigate the feasibility of the implementation of National Health Insurance;
- To gauge the extent and implications of the additional burden on South Africa's relatively small tax base which would be required to finance National Health Insurance.

1.3 Methodology

The research methodology applied in this essay is interpretative and qualitative methodological approaches were adopted. This paper was researched in a South African context, although international comparisons were made.

The main method of collecting information for this paper was through an extensive analysis of the available literature with regard to the debate surrounding NHI in South Africa.

This topic is subject to ongoing debate and has spawned a vast volume of literature. For the purposes of this research paper, only those texts which are relevant to the feasibility and practicality of National Health Insurance as well as those which relate to the taxation implications of the policy were analysed. It was anticipated that there would be strong support and criticism of the proposed NHI and thus literature from both sides of the argument were examined. Due to the fact that this paper focuses on a government plan which is in the process of being implemented, only recent works were considered for analysis.

This research essay concerns state policy and thus a comprehensive analysis of documents produced by the government which relate to the topic was performed; an example of such a document is the Green Paper released by the Department of Health on 05 August 2011 entitled "National Health Insurance in South Africa". Another document which was considered is one which was produced by the African National Congress in 2010 at the National General Council. This document sets out in detail the ruling party's proposal for NHI in South Africa.

In order to adequately put this research paper into context it was necessary to consult literature which deals with the current challenges faced by the health sector in South Africa and the apparent need for NHI in the country. It is however important to note that the primary concerns of this research was the feasibility and practicality of the proposed NHI as well as the anticipated increased taxation burden and thus an in-depth discussion on the burden of disease and other such topics was irrelevant.

1.4 Ethical considerations

All of the documentary evidence that was consulted for the purposes of this research is in the public domain and thus no ethical considerations arise.

1.5 Overview of chapters

Chapter 1 puts the research into context, sets out the research goals, describes the research methodology used, details the ethical considerations and provides an overview of the chapters.

Chapter 2 discusses the history of the present challenges faced by the South African health care system. The current problems in the health system are examined and consideration is given as to how they might create an apparent need for the implementation of NHI in the country. A discussion of the current problems serves to indicate the extent of the funding required and therefore the taxes that need to be raised to meet the needs.

Chapter 3 considers the evolution of health reform in South Africa and how policy-makers have arrived at the current proposal for NHI in South Africa. There is also a discussion of the key policy ideas of NHI and what is included in the proposed comprehensive benefit package. Also, attention is given to the key objectives and goals of the NHI, specifically the aims of the proposal. A detailed discussion of the concept of 'universal coverage' is also included, as well an evaluation of South Africa's progress towards achieving it. Finally, consideration is given to the migration process from the current health care system to NHI.

Chapter 4 commences with a review of the present health care expenditure in South Africa and how this spending is currently funded. An explanation of revenue collection, pooling, and purchasing is also provided.

Chapter 5 explores both sides of the feasibility debate by analysing the estimated costs of National Health Insurance and considering the relevant tax implications of the proposal.

Chapter 6 provides recommendations for health care financing in South Africa, taking into account the findings of the present paper. The chapter also includes the limitations of the present paper and opportunities for further research.

Chapter Two: The current South African health system

2.1 Introduction

Prior to an analysis of the feasibility and practicality of the proposed NHI and the accompanying tax implications it is necessary to discuss the origins of the present challenges faced by the South African health care system. Furthermore, the current problems in the health system should be examined and consideration must be given as to how they might create an apparent need for the implementation of NHI in the country. A discussion of the current problems will also serve to indicate the extent of the funding required and therefore the taxes that need to be raised to meet the needs.

2.2 Roots of the current problems in the health system

South Africa has a political past which has been plagued by colonial suppression, racial and gender discrimination, the migrant labour system, immense income inequalities, excessive violence and the destruction of family life (Coovadia *et al*: 2009). According to Coovadia *et al* (2009), each of these aspects of the country's history has had adverse consequences for the population's health and the provision of health care services.

With the discovery of diamonds in Kimberly in 1867 and gold in the Witwatersrand in 1886, mining became the foundation of the economy and continued to be so well into the 20th century (South African History Organisation: 2000). The development of the manufacturing sector was closely linked to mining and a sudden surge in foreign investment flowed to the country (SAHO: 2000). Coovadia *et al* (2009) notes that this increased potential for wealth generation led to merciless methods of obtaining cheap black male labour and a combination of restrictions on access to land and means of production and strict controls of movement, meant that male labourers migrated to the towns.

The migrant labour system became the key feature of social, economic, and political developments and played a significant role in the determination of disease patterns as well as the degradation of the rural black agricultural economy (Coovadia *et al*: 2009).

Between 1921 and 1936 the urban black population grew by 94% and with a failure to provide housing for the migrant workers, the creation of overcrowded, unsanitary hostels and

slums occurred in the black urban areas (Hellman & Rooiyard: 1948). There was a high turnover of mine workers as a result of them either returning home to their families in the rural areas or simply being too ill to continue working. The result was that by the late 1920s, more than 90% of adults in parts of the Transkei and Ciskei had been infected with tuberculosis (Packard: 1989).

The migrant labour system affected the sexual practices of the black population, many of whom would have sexual partners in the rural areas as well as in the towns. The system thus contributed greatly to the spread of sexually transmitted diseases (Coovadia *et al*: 2009).

The political exclusion, economic marginalisation, social separation and racial injustices of the preceding 300 years were consolidated by the state policy of apartheid in 1948 (Coovadia *et al*: 2009). The system involved the strict racial classification of all South Africans and a racial hierarchy with white people situated at the top.

The classification had a strong bearing on the resources allocated to a person's education, health care and pensions (Coovadia *et al*: 2009). For example, in 1980, the expenditure per black child's education was one fifth of that spent per white child. The opinion of Bantu education was that black people should only be educated so far as to equip them for a menial position in society and focused on the deliberate under-education of black people (Terreblanche: 2002).

Further factors which have contributed to the current health problems were subordination of women, disrupted family life, poverty and conflict. According to Coovadia *et al* (2009), the involvement of many black and coloured young men in criminal gangs can be explained by the fact that apartheid had made many traditional aspects of adult manhood impossible to achieve, especially a family and the fulfilment of a provider role.

Coovadia *et al* (2009), expresses the view that apartheid had a major effect on the structure of the black family through the migrant labour system and the general impoverishment of the African population. During the 1950s, as poverty deepened, marriage became increasingly unaffordable for the groom as they were unable to pay *lobola* (bride wealth) and it was commonplace for children to be raised without fathers (Coovadia *et al*: 2009). Coovadia *et al* (2009) believes that this magnified the problem of childhood poverty and damaged the process of socialisation in children into disciplined and responsible adults.

Medical training was also racially segregated from the start and in the 1930s there were fewer than ten black doctors in the whole country and between 1968 and 1977 only 3% of doctors graduating were black (South African Medical School Trust: 1981). Marks (1994) notes that up until the 1970s, black nurses could not treat white patients or have white subordinates and, until 1986, had lower salaries than white nurses. Under apartheid, all senior management positions throughout the health system were occupied by white males.

During apartheid there were separate hospitals for black and white people, resulting in a structure that was highly inefficient with duplication of both administrative functions and clinical services (McIntyre, Thiede, Nkosi, Mutyambizi, Castillo-Riquelme, Gilson, Erasmus, & Goudge: 2007). McIntyre *et al* (2007) also highlights the fact that health services in the rural and township areas were systematically under-funded as a result of apartheid policies.

A key influence on the health of South Africans has been the impoverishment of the black population brought on by low wages, overcrowding, inadequate sanitation, malnutrition and stress (Coovadia *et al*: 2009). According to Coovadia *et al* (2009), these factors have combined to create a high burden of poverty-related diseases and that income inequalities have had a major influence on the high levels of crime and violence.

It is thus clear that the distinguishing features of South Africa's history that have determined the current health problems include racial and gender discrimination, income inequalities, the migrant labour system, the destruction of family life, and violence. These problems have, in turn, contributed to the HIV/AIDS pandemic and the prevalence of tuberculosis that will place a heavy financial burden on the proposed NHI.

2.3 Problems with the current health system

In South Africa there is a two-tier health system which is fragmented along socio-economic lines with the majority of the population reliant on the relatively under-resourced, tax funded, public sector health care facilities, whilst the minority of the well-off are covered by private health insurance and access the private health sector for all their medical needs (McIntyre *et al*: 2007).

Since apartheid, the disparities have widened in the resources available to each sector of the health system, in relation to the population that each caters to. In 2005, spending levels per

medical scheme member were approximately R9,500, yet they were less than R1,300 per person entirely dependent on the public sector for health care (McIntyre *et al*: 2007).

According to the ANC (2010), the mismatch of resources in the public and private health sectors relative to the size of the population that each serves has contributed to the very poor health status of South African citizens, particularly those in the lowest income brackets.

According to Econex (2009), South Africa faces a unique health challenge in that it has what is described as a quadruple burden of disease, made up of the following:

- HIV/AIDS
- Injuries
- Diseases of lifestyle
- Poverty-related conditions (including tuberculosis).

This burden of disease is on average four times larger than that of developed countries, and in most cases almost double that of developing countries (Econex: 2009). According to Coovadia *et al* (2009), South Africa is considered to be a middle-income country in terms of its economy, yet it has health outcomes that are worse than those found in many lower income countries. The ANC (2010) note that the country has far higher infant mortality rates and a far lower life expectancy than other countries with similar levels of economic development.

McIntyre *et al* (2007) makes the observation that there is a strong relationship between health and socio-economic status in South Africa. The Gini coefficient is a measure of income inequality and ranges from 0, which reflects complete equality, to 1, which represents total inequality (Coovadia *et al*: 2009). According to Statistics South Africa (2008), the country's Gini coefficient was 0.56 in 1995 and had increased to 0.73 in 2005. This figure is 0.8 if social grants are disregarded. It is thus evident that the gap between the rich and the poor is becoming wider and there is a severe case of income inequality in South Africa.

Coovadia *et al* (2009) makes the point that income inequalities have had a major influence on the high rates of crime and violence in the country. Rape and violence increase the vulnerability of women to HIV/AIDS and teen pregnancy (Coovadia *et al*: 2009). According to Bradshaw, Nannan and Laubscher (2007), the reported number of rapes in 2006 was 54926 and it is estimated that every six hours a woman in South Africa is murdered by an intimate partner.

Coovadia *et al* (2009) questions the logic of the current government's policy of restricting expenditure even though there are obvious income inequalities, a failing education system, a 40% unemployment rate and an HIV/AIDS epidemic. Since the end of apartheid there has been stagnation in government expenditure on the public health sector which, when coupled with the growing disease burden, has put extreme pressure on the health care system in the country (ANC: 2010). According to ANC (2010), the reason for the lack of government spending is the Growth, Employment and Redistribution (GEAR) policy which seeks to reduce the budget deficit.

At the end of apartheid, the ANC government inherited a budget deficit which amounted to nearly 45% of gross domestic product (Department of Finance: 1996). In 2007, for the first time since the 1950s, government revenue exceeded government expenditure (Coovadia *et al*: 2009). This achievement is partly due to vastly improved tax collection systems by the South African Revenue Service (SARS), but is largely as a result of the aforementioned constraints placed on government expenditure (McIntyre *et al*: 2007). According to Coovadia *et al* (2009), spending on social services, especially health and education, was very limited in the 1990s and has only seen increases in recent years. Coovadia *et al* (2009) notes, however, that this increase is mostly attributable to additional social grants.

The most striking problem of the current health care system in South Africa is the human resource crisis it is facing (Coovadia *et al*: 2009). According to the ANC (2010), the shortage of key health professionals is being experienced at a time when the number of people dependent on public health care has been increasing, and the burden of disease, primarily due to HIV/AIDS and tuberculosis, is on the rise.

Despite the fact that 60% of the health budget is being spent on human resources, since 1994 the health sector has been affected by a legacy of misdistribution of staff and poor skills of many health care personnel (Coovadia *et al*: 2009). Coovadia *et al* (2009) views the policy decision to offer voluntary severance packages to public sector staff in the mid-1990s as unfortunate. This had the effect of moving skilled staff out of the public sector and into either early retirement or the private sector. According to Day and Gray (2007), the number of doctors working in the private sector increased from 40% in the 1980s to almost 80% in 2007.

Coovadia *et al* (2009) is alarmed by the closure of several nursing colleges at a time when health care workers are in high demand and notes that the number of students graduating

from medical training is far too low to offset the shortage of professionals. A further concern, which is expressed by Reid (2003), is that 43% of doctors in compulsory community service stated their intention to leave South Africa to work overseas.

After apartheid, considerable effort was made to include women and black people in senior and top management teams in the public health sector (Coovadia *et al*: 2009). According to Coovadia *et al* (2009), this policy decision contained many flaws, including the loss of institutional memory, the hiring of inexperienced and incompetent personnel, a shortage of training, support and supervision and the stubborn tendency to retain underperforming senior staff and leaders.

The only performance measurement indicator on which these inexperienced senior level management staff is being held accountable is that of cost-containment (Coovadia *et al*: 2009). As mentioned previously, there are concerns over a lack of government spending and it is suggested that more appropriate performance controls would be those relating to patient treatment rates and the improvement of the general population's overall health status.

Coovadia *et al* (2009) is of the opinion that the problem lies with the belief that people are a product of their past and that it is therefore unfair to hold individuals accountable for actions and values that have been moulded through apartheid oppression. It is also suggested by Coovadia *et al* (2009) that it is perhaps unreasonable to hold people accountable for their inability to manage and deliver if they were never given an adequate education to equip them to do so.

It is apparent that the current South African health care system is dysfunctional. There is a vast disparity of resources available to the public and private health sectors, a quadruple burden of disease, income inequalities, high levels of rape, violence and unemployment, a lack of government spending on social services, and weak senior level management. To face these current health care challenges, there is without a doubt a call for a system overhaul and perhaps the proposed NHI could offer a solution.

2.4 The need for a National Health Insurance

The ANC (2010) believes that the implementation of NHI will greatly aid in addressing the vast inequalities that continue to plague the health system in South Africa, especially the distorted distribution of funding and human resources between the public and private sectors.

In order to fully address these imbalances, the ANC (2010) suggests that the health care system requires fundamental transformation through the introduction of NHI that allows for an integrated, pre-payment based mechanism and ensures the realisation of the right to health care for all.

In terms of section 27 of the Constitution of the Republic of South Africa (Act No. 108 of 1996),

1) *everyone has the right to have access to -*
    a) *health care services, including reproductive health care;*
    b) *sufficient food and water; and*
    c) *social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.*
2) *The state must take reasonable legislative and other measures, within it available resources, to achieve the progressive realisation of each of these rights.*
3) *No one may be refused emergency medical treatment.*

It is evident that the ANC believes that not all South Africans are currently fully enjoying these constitutional rights and that it is necessary for them to take action by proposing and implementing a NHI system.

The ANC (2010) firmly believes that the status quo in the South African health system cannot continue and that the rationale for introducing a NHI is that it would provide a mechanism for improving cross subsidization in the overall system, whereby an individual's ability-to-pay dictates their contribution and benefits are matched to an individual's need for care.

Econex (2009) highlights the fact that in designing the NHI, South Africa will have to take into account the unique quadruple burden of disease the country faces. The resource requirements, rationing systems, and the financial and costing demands will be completely different from a country with a single burden of disease and where the severity thereof is less than a quarter of South Africa's (Econex: 2009).According to Econex (2009), it is important to have a good understanding of the makeup of the demand side and what supply constraints exist in order to fully determine the optimal design of a South African NHI.

Econex (2009) warns that the expectation that a South African NHI, similar to the NHS of the United Kingdom, could be introduced in a short time frame is overoptimistic. It is suggested

by Coovadia *et al* (2009) that innovative approaches to health service delivery are required in developing countries that are dealing with remarkably different health challenges to that of developed economies.

According to the ANC (2010) it is a well-known fact that the private health sector currently commands the health resources in South Africa, yet it only serves a minority section of the population and this has been to the detriment of the public health sector on which the large majority of the country's citizens depend.

The ANC (2010) is of the opinion that a free market for health care produces inequitable and inefficient results and that a single funding pool would go a long way to addressing the current imbalances in the current health system.

McIntyre *et al* (2007) agree with this viewpoint and suggests that the activities of the public and private health sectors should be integrated in a way that makes optimal use of all available resources. The ANC (2010) argues that the current funding for health services in South Africa is fragmented on various legislative and policy levels, leading to inefficient resource utilisation, wasteful health cover duplication and unnecessary overlapping of functions. Thus, as proposed by McIntyre *et al* (2007), there is a need to unite the public and private sector resources to promote common goals.

The ANC (2010) stresses that public financing of health care does not imply that that all health care is provided by the public sector and notes that many countries utilize public funds to contract private doctors.

According to the ANC (2010), due to high monthly premiums, membership of private medical schemes is becoming increasingly unaffordable for South Africans. McIntyre *et al* (2007) highlight the fact that even high income earning individuals who are covered by private medical aid can face potentially substantial out-of-pocket payments for service fees which lie outside their specific benefit package.

In a 2008 national household survey, 76% of all respondents agreed with the statement: "I would agree to pay a small amount each month so that if I get sick, health care will be free, even if I am not sick now" (ANC: 2010). This shows that there is a good support amongst the general public for NHI.

In the same survey, 67% agreed with the statement: "I would join a publicly supported health insurance system if my monthly contribution was less than for current medical schemes" (ANC: 2010). The ANC (2010) points out that 82% of respondents who are currently members of private medical schemes were in agreement with this statement, further demonstrating the public support for NHI.

The private health insurance sector contains highly fragmented risk pools with over 130 different schemes serving a population of less than seven million people (McIntyre *et al*: 2007). Furthermore, McIntyre et al (2007) note that there are a number of benefit options within each private scheme and that it would serve the country better to have a single pool of risk.

According to the ANC (2010), in 2005 the expenditure subsidy for medical scheme contributors through tax deductions was estimated to be around R10 billion of foregone revenue, which translates to 20% of the public health sector budget. The ANC (2010) believes that this tax policy contains major flaws and is inconsistent with the principles of universal access, efficiency and equity and a key concern is that workers not covered by medical schemes benefit nothing from the tax subsidy.

The ANC (2010) is in strong support of NHI and believes that it will lend itself to a healthier population which translates into a productive and effective workforce that grows local business, attracts foreign investors and expands the South African economy. In addition, the ANC (2010) trusts that NHI would protect the poor, prevent cost escalation in the private medical insurance market, and ultimately, help to secure a wealthier future for South Africa.

According to Coovadia *et al* (2009), the initiative will require more government spending on health care and better distribution of resources. Furthermore, Coovadia *et al* (2009) point out the need for political leadership and social interventions directed at promoting a more responsible, caring, and non-violent masculinity.

2.5 Conclusion

The most prominent elements of South Africa's past that have determined the current health problems in the country include racial and gender discrimination, income inequalities, the migrant labour system, the destruction of family life, and violence.

It is clear that the current South African health care system is in disarray with immense disparities of resources available to the public and private health sectors, a quadruple burden of disease, income inequalities, high levels of rape, violence and unemployment, a lack of government spending on social services, and weak senior level management. To combat these current health care challenges, there is without a doubt a need for a complete system overhaul.

Current senior level management employees are rewarded purely on their ability to contain costs and little emphasis is placed on accountability for service delivery to the public. A NHI is necessary in order to address the imbalances which have cursed the health system in South Africa for centuries. The introduction of a NHI is aimed at strengthening the under-funded and over-worked public health sector and pooling of all health resources in the country in an effort to realise the constitutional right of all South Africans to access quality health care services.

The next chapter will explore the history of health reform in South Africa and analyse the current proposal for NHI in South Africa. There will also be a discussion of the concept of 'universal coverage' and as well the migration process from the current health care system to NHI.

Chapter Three: Health reform and National Health Insurance

3.1 Introduction

Prior to an analysis of the feasibility and practicality of the proposed NHI and the accompanying tax implications it is also necessary to consider the evolution of health reform in South Africa and how policy-makers have arrived at the current proposal for NHI in South Africa. Furthermore, it is important to discuss the key policy ideas of NHI and what will be included in the proposed comprehensive benefit package. Also, attention must be given to the key objectives and goals of the NHI, specifically looking at what the proposal aims to achieve. A detailed discussion of the concept of 'universal coverage' will follow, with an evaluation of South Africa's progress towards achieving it. Finally, consideration will be given to the migration process from the current health care system to NHI.

3.2 Brief history of health reform in South Africa

There is a common misconception that health reform in South Africa is only a recent concern for government policy-makers. In fact, proposals to overhaul the inequitable and inefficient health care system in South Africa have been put forward and debated for more than 80 years (Department of Health: 2011).

In 1928, the Commission on Old Age Pension and National Insurance proposed that a health insurance scheme should be put in place in order to cover medical, maternity and funeral benefits for all low income formal sector employees in urban areas (DOH: 2011). Similar suggestions were put forward in 1935 by the Committee of Enquiry into National Health Insurance, but neither of these two proposals was ever implemented (DOH: 2011).

The early 1940s the Gluckman Commission proposed the implementation of a National Health Tax aimed at ensuring free health service provision at the point of service for all South Africans irrespective of race or socio-economic status (DOH: 2011). Jan Smuts' government accepted the proposal and within two years 44 community health centres were established, but any gains were reversed after the election of the National Party government in 1948 led by DF Malan (DOH: 2011).

The apartheid years saw no progression towards any form of national health insurance schemes and it was not until democracy was achieved that further suggestions surfaced. The Health Care Finance Committee of 1994 recommended that all formally employed persons and their immediate dependants should at first make up the core membership of social health insurance with the idea of expanding coverage to other groups over time (DOH: 2011).

According to DOH (2011), since the Health Care Finance Committee of 1994, the following bodies have been formed over the years to aid the government in implementing an effective and sustainable national health insurance in South Africa:

- 1997: Social Health Insurance Working Group (leading to the enactment of the Medical Schemes Act in 1998);
- 2002: Committee of Inquiry into a Comprehensive Social Security for South Africa (Taylor Commission);
- 2002: Ministerial Task Team on Social Health Insurance;
- 2005: Ministerial Task Team for Implementing Social Health Insurance; and
- 2009: Ministerial Advisory Committee on National Health Insurance.

According to the DOH (2011), the rationale for the implementation of NHI is to remove the current two-tiered system where those with the most significant need for health care have the least access and have undesirable health outcomes. In the opinion of the DOH (2011), the system will provide a mechanism for improving cross-subsidization, whereby funding contributions are linked to a person's ability-to-pay and benefits would be in line with an individual's need for care. At a later stage it will be shown how these principles relate to the concept of universal coverage.

An NHI fund will be established with the main responsibility of receiving funds, pooling these resources and purchasing health care on behalf of the entire population (ANC: 2010). The fund will be managed by a Chief Executive Officer who will report directly to the Minister of Health, similar to the manner in which the SARS Head reports to the Minister of Finance (ANC: 2010). According to the ANC (2010), a single payer system is effective in collecting revenue, distributing risks through one large risk pool, and offers the government a high degree of control over the total expenditure on health care in the country. Kirby (2009), remarks that the NHI can be viewed as one large medical scheme.

The pool is expected to draw funds from general tax revenue, as well as a form of mandatory health insurance contribution from those employed in the formal sector by way of a payroll tax (Kirby: 2009). Furthermore, Ataguba and Akazili (2010) note that it is important to understand that because NHI is to be financed through general taxation, all South Africans, including the poor and the unemployed, will be contributing towards funding the system in the form of indirect taxes such as VAT and fuel levies.

The ANC (2010) provides a list of what will be included in the comprehensive package of services covered by the NHI Fund:

- *Primary care and preventive services;*
- *Inpatient care;*
- *Outpatient care;*
- *Emergency care;*
- *Prescription drugs;*
- *Appropriate technologies for diagnosis and treatment;*
- *Rehabilitation;*
- *Mental health services;*
- *The full scope of dental services (excluding cosmetic dentistry);*
- *Substance abuse treatment services;*
- *Basic vision care and vision correction (excluding laser vision correction); and*
- *Hearing services (including the provision of hearing aids).*

Ataguba and Akazili (2010) explain that this comprehensive package of healthcare services to be covered by the NHI Fund will be provided through accredited and contracted public and private providers. According to the DOH (2011), accreditation will be granted to public and private establishments once they have met set standards of quality measured on the basis of safety and access, service elements, management systems, performance standards and coverage.

For individuals who desire cover for additional health care services over and above the comprehensive package offered by the NHI, optional enrolment to existing private medical schemes will still be available (Ataguba and Akazili *l*: 2010). It is important to note that any payments made directly to a private medical scheme would be in addition to the mandatory

NHI contribution. The DOH (2011) points out that the current tax subsidy will no longer be available to those who choose to continue with medical cover.

3.3 Objectives of National Health Insurance

The Green Paper on National Health Insurance provides the following objectives for NHI (DOH: 2011):

a) *To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not.*
b) *To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.*
c) *To procure services on behalf of the entire population and efficiently mobilize and control key financial resources. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling costs.*
d) *To strengthen the under-resourced and strained public sector so as to improve health systems' performance.*

The DOH (2011) is concerned that the two-tiered health care system has failed to embrace the principles of equity and access and that the current health financing mechanisms do not facilitate the attainment of these noble goals. The key driving force behind all of these NHI objectives is the constitutional right to health care access discussed in Chapter 2 of this research paper.

Ataguba and Akazili (2010) note that the primary aim of NHI is the provision of 'universal coverage', which is defined by the World Health Organisation (WHO) as

> *the progressive development of a health system including its financing mechanisms into one that ensures that everyone has access to quality, needed health services and where everyone is afforded protection from financial hardships linked to accessing these health services*

According to McIntyre (2010a), various definitions of universal coverage are offered by numerous sources, but they all contain two common elements. Firstly, a universal health system ensures that everyone is able to use required health services by eliminating barriers to access. The second principal of universal coverage offered by McIntyre is that financial protection should be provided for all against the costs of health care by pooling risks and

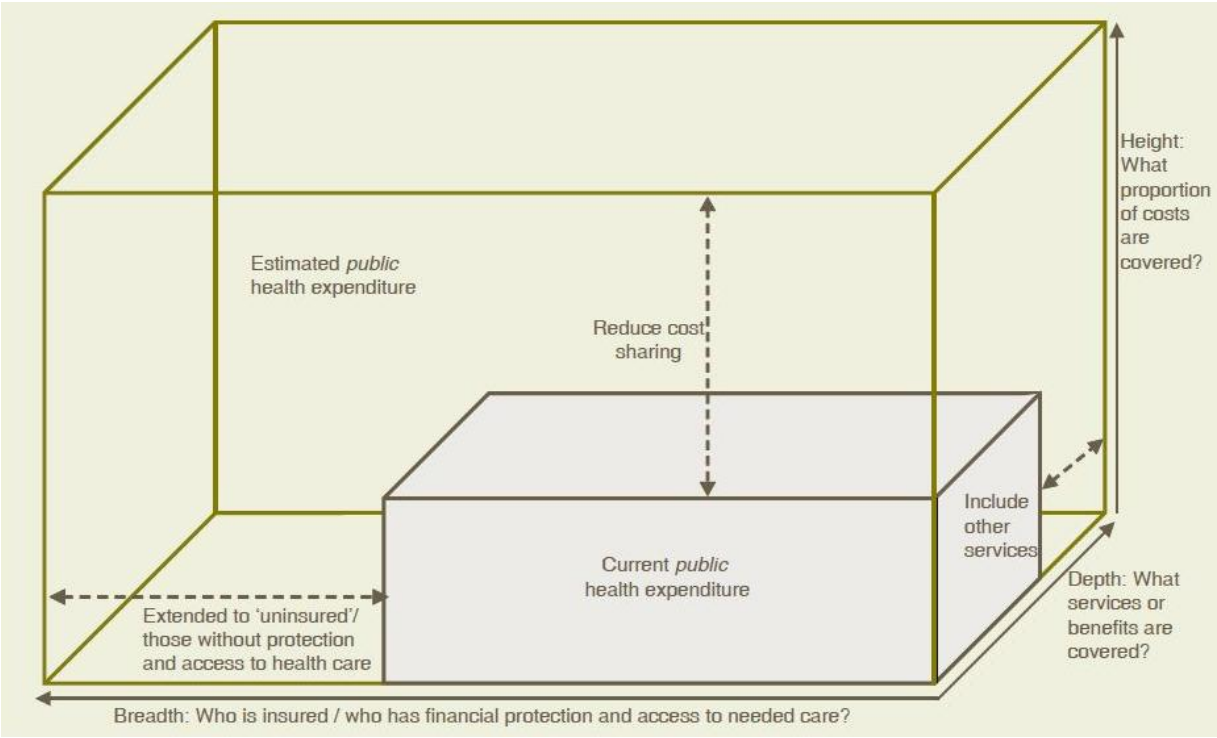
resources and through 'pre-payment' mechanisms. The concept of universal coverage will be discussed in detail next.

3.4 Universal coverage

According to McIntyre (2010a), the underlying equity principles of universal coverage are:

- *contributing to funding health services according to ability-to-pay; and*
- *benefiting from health care according to need.*

Figure 1: Graphical presentation of breadth, depth and height of coverage



Source: Mathauer (2009)

Figure 1 above provides a graphical representation of the concept of universal coverage. The inner cube shows the current public health expenditure. In order to achieve universal coverage in South Africa, it is necessary to for the inner cube to reach the same size as the outer cube; essentially, the height, breadth, and depth of the inner cube all need to be extended.

The three dimensions of the cube are explained by DOH (2011) as follows:

- The **breadth** of coverage refers to the proportion of the population that has access to essential health services and that has financial protection.
- The **depth** of coverage refers to the extent to which the range of services required to address the health needs of the population are covered.
- The **height** of coverage refers to the extent to which health care costs are covered through pooling and pre-payment mechanisms.

To achieve the maximum possible breadth of coverage it is necessary to extend current financial protection and access to health care to that portion of the population which is at present uninsured and to those who face difficulties in accessing health services (McIntyre: 2010a).

According to McIntyre (2010a), only 16% of the South African population are currently members of a medical scheme. With 71% of medical scheme members being in the richest quintile of South African households and 18% in the second quintile, it is evident that membership of these schemes is limited to only the wealthiest groups (McIntyre, Okorafor, Ataguba, Govender, Goudge & Harris: 2008).

Furthermore, access to health care is also very restricted in South Africa (McIntyre: 2010a). McIntyre *et al* (2008) reveal that the overall average travelling time to a health facility for the poorest 20% of households is 40 minutes and that spending on transport for a single visit to a health care centre for the same group of people amounts to 11% of their monthly household expenditure.

It is thus evident that there is a strong need to extend the breadth of coverage as very few people in South Africa have financial protection against health care costs and with access to health facilities in the country.

In order to extend the depth of coverage, it is necessary to expand the package of health services to ensure that a comprehensive range of services is provided with regard to the most pressing health needs of the population (McIntyre: 2010a). According to McIntyre, medical schemes cover only a limited and very specific range of services and the more comprehensive packages require high contributions by the members.

The public sector faces resource constraints and public health professionals are required to prescribe from the essential drug list, which includes only a limited number of mostly generic medicines (McIntyre: 2010a).

There are clearly severe gaps in the depth of coverage in the South African health care system in both the private and public sectors.

Efforts to arrive at universal coverage will require the height of coverage to be improved through reducing the extent to which health services are funded through out-of-pocket payments, by increasing pre-payment funding (McIntyre: 2010a). Surprisingly, McIntyre notes that the height of coverage in South Africa can be described as being relatively good due to the fact that the majority of health care funding actually occurs through pre-payment mechanisms.

Only about 15% of total health care funding is obtained via out-of-pocket payments, which is relatively low compared to other low- and middle-income countries (McIntyre *et al*: 2007). Out-of-pocket payments comprise of the following (McIntyre: 2010a):

- *User fees paid at public hospitals;*
- *Payments to private providers by non-insured citizens;*
- *Payments by medical schemes members either as co-payments or in full for services not covered in their benefit packages.*

McIntyre (2010c) provides an interesting statistic in that 60% of all out-of-pocket payments in South Africa are made by members of medical schemes, thus highlighting the extent to which they are not fully protected from the costs of health care. According to Ataguba and Akazili (2010), the remaining 85% of health care is financed 40% by general tax revenue and 45% by private medical schemes.

In order for universal coverage to be achieved, considerable social solidarity is required; a social principle which, according to Ataguba and Akazili (2010), is often enshrined in African cultures. The important benefits of solidarity, as described by Ataguba and Akazili, is that it allows for cross-subsidisation of the poor by the rich (income cross-subsidy), and the sick by the healthy (risk cross-subsidy).

An important consideration is the fact that South Africa has the highest total per capita health care spending level (including both the private and public sector spending), in Africa (Ataguba *et al*: 2010). Thus, although this implies that there is relatively adequate per capita health care spending to provide care for everyone, the current distribution of such spending between the public and private sectors relative to the populations served by each means that

with regard to the resources available in South Africa, universal coverage has not been achieved (Ataguba & Akazili: 2010).

It would thus appear that the dimension of universal coverage which requires the most attention in South Africa is that of the breadth of coverage. Any policy decisions must be primarily aimed at addressing the issues of improving access to health care and ensuring that a higher proportion of the population is protected against health care costs.

3.5 Moving from the current health system to National Health Insurance

The ANC (2010) realises that the introduction of NHI requires a substantial transformation of the South African health care system. According to the DOH (2011), the implementation of NHI will be done in a phased manner and the DOH estimates that the migration period will be over fourteen years. Each aspect of the transitional process will now be discussed.

District health structures

It is necessary to formulate a plan that looks at establishing and strengthening of the provincial and district health structures in order to support service delivery within the NHI (ANC: 2010). According to the DOH (2011), this will entail the acceleration of the re-engineering of the Primary Health Care Approach through the creation of municipal family health teams, district-based specialist teams and the implementation of school-based health programmes.

Accreditation of providers

The ANC (2010) note that a comprehensive plan for quality improvement, assurance and compliance for all providers (both public and private), will be required. Inspection, licensing and certification of all health care facilities will be carried out by the Office of Health Standards Compliance and accreditation will be given based on prescribed criteria and standards (DOH: 2011).

Human resources

A key part of the transitional process will be a plan for addressing the current human resource shortages in the health care system and the hiring of additional human resources to enhance service delivery within the NHI (ANC: 2010). According to the DOH (2011), this will

include increasing the capacity of nursing colleges and health science faculties in an effort to produce more health care professionals.

Service package

The DOH (2011) is aware that a crucial element of the piloting phase will be the evaluation of the appropriateness of the comprehensive service package (as detailed above) and the ability of the accredited providers to actually deliver this package at an appropriate level of care.

Existing health infrastructure

A further requirement of the migration process will be the assessment of existing health infrastructure as well as a plan for improving its capacity and effectiveness to support the delivery of health services within the NHI (ANC: 2010).

Hospital management

With regard to transforming the South African health care system, another initiative revealed by the DOH (2011) is the implementation of hospital management reforms that include governance modifications, decentralisation of authority associated with hospital management autonomy, improvements in financial management and better accountability systems.

Purchasing and procurement

In order to allow for the most efficient economies of scale under the NHI, the ANC (2010) recognises the need for the development of a plan that informs the processes of implementing innovative purchasing, contracting and procurement processes.

Population registration

The movement to NHI also requires an integrated plan to support processes for the registration of the population (ANC: 2010). According to the DOH (2011), this plan will also include conducting research on the type of NHI card that will be used to allow the insured population to be identified.

Revenue collection and pooling

In order for the NHI to provide the appropriate financial risk protection for the entire population and for it to yield the full economies of scale, the transitional process will include the refinement of the revenue collection strategy and of the pooling systems (DOH: 2011).

Provider payment mechanisms

When moving from the current reimbursement system to the proposed performance-based payment system under the NHI, the DOH (2011) notes that the reform will include the refinement of the provider payment mechanisms.

Health information system

According to the ANC (2010), the current fragmented health information system will be transformed into an integrated health information system that supports efficiency, effectiveness, information portability, patient confidentiality and enhanced proactive decision-making.

Legislation

An important element of the transitional process will be the review of existing health legislation to inform the preparation of the Act that will create an enabling environment for the implementation of NHI in South Africa (ANC: 2010). The actual passing of the enabling legislation will form part of this transformation process (DOH: 2011).

Piloting

A grant will be allocated to the Department of Health for the piloting of the NHI to fund the shadow processes for implementing and rolling out of the key service delivery, administrative and technical functions required for the first few years (DOH: 2011). According to the DOH, the first steps towards the implementation of NHI in South Africa will take place in 2012 through piloting programmes in ten selected districts. Health profiles, demographics, health delivery performance, management of health institutions, income levels and social determinants of health will all be criteria for choosing these ten districts (DOH: 2011).

According to the ANC (2010), each one of the elements of the transitional process discussed above will be guided by principles of equity, effectiveness, appropriateness and efficiency.

Table 1 below provides a summary of the key features of the migration process and the expected time frames of each.

Table 1: Phasing-in of NHI – The first five years

Key features	Time-frames
1. NHI White Paper and Legislative Process	
Release of White Paper for Public Consultation	10-Aug-11
Launch of Final NHI Policy Document	Dec-11
Commencement of NHI Legislative process	Jan-12
2. Management reforms and Designation of Hospitals	
Publication of Regulations on Designation of Hospitals	Aug-11
Policy on the management of hospitals	Aug-11
Advertisement and appointment of health facility managers	Oct-11
3. Hospital Reimbursement reform	
Regulations published for comment on Hospital Revenue Retention	Apr-11
Development of a Coding Scheme	Jan-12
4. Establishment Office of Health Standards Compliance (OHSC)	
Parliamentary process on the OHSC Bill	Aug-11
Appointment of staff (10 inspectors appointed)	Jan-12
5. Public Health Facility Audit, Quality Improvement and Certification	
Audit of all public health facilities	
• 21 % already audited (876 facilities)	End July 2011
• 64% completed (2927 facilities)	by end of December 2011
• 94% completed (3962 facilities)	by end March 2012
Selection of teams	Oct-11
Initiate inspections by OHSC in audited and improved facilities	Feb-12
Initiation of certification of public health facilities	Mar-12
6. Appointment of District Clinical Specialists* Support	
Identification of posts and adverts	Aug-11
Appointment of specialists	Dec-11
Contract with academic institutions on a rotational scheme	Feb-12
7. Municipal Ward-based Primary Health Care (PHC) Agents	
Training of first 5000 PHC Agents	Dec-11
Appointment of first 5000 PHC Agents	Mar-12
Appointment of PHC teams	Apr-12
8. School - based PHC services	
Establish data base of school health nurses including retired nurses	Aug-11
Identification of the first Quintile 1 and or Quintile 2 schools	Oct-11

Appointment of school-based teams led by a nurse	Nov-11
9. Public Hospital Infrastructure and Equipment	
Refurbishment and equipping of 122 nursing colleges	Mar-12
• First 72 nursing colleges by end of financial year 2011-2012	
Building of 6 Flagship hospitals and medical faculties through PPP's	**Commence 2012**
• King Edward VIII Academic (KZN)	
• Dr George Mukhari Academic (Gauteng)	
• Nelson Mandela Academic (E. Cape)	
• Chris Hani Baragwanath Academic (Gauteng)	
• Polokwane Academic (Limpopo)	
• Nelspruit Tertiary (Mpumalanga)	
Refurbishment of public sector facilities	Ongoing
10. Human Resources for Health (HR)	
Launch of HR Strategy	Sep-11
Short to medium term increase in supply of medical doctors and specialist	2012 – 2014
Increase in production of nurses	2012 – 2014
Increase in production of pharmacists	2012 – 2014
Increase in production of allied health professionals	2012 – 2014
11. Information Management and Systems Support	
Establishment of a **National Health Information Repository and Data Warehousing** (NHIRD)	Jul-11
Provincial and District roll-out of the NHIRD	Nov-11
Appointment of Information Officers and Data Capturers	Nov-11
12. Build capacity to manage NHI through the strengthening of District Health Authority	**Apr-12**
Creation of NHI district management and governance structures	
Selection of Pilot Sites (First 10 districts)	
Development and test the service package to be offered under NHI in pilot sites	
Extension of Pilots from 10 districts to 20 districts	Jun-13
13. NHI Conditional Grant to support piloting of initial work in 10 districts	**Apr-12**
Piloting of the service package in selected health districts	
Piloting fund administration	
14. Costing model	
Refinement of the costing model	2012
Revised estimates	2013
15. Population registration	**Commences Apr 2012**

Partnership between Departments of Science and Technology, Health and Home Affairs on:	
• Population identification	
• Population registration mechanisms	
16. ICT	**Apr-12**
Scoping exercise with Department of Science and Technology and CSIR	
• Design of ICT architectural requirements for NHI	
17. Establishment of NHI Fund	**2014**
Appointment of CEO and Staff	
Establishment of governance structures	
Establishment of administrative systems	
18. Accreditation and contracting of private providers by NHI Fund	
Establishment of criteria for accreditation	2013
Accreditation of first group of private providers	2014

Source: DOH (2011)

3.6 Conclusion

Although the NHI appears to have been a topic of hot debate in recent years, it would appear that health reform in South Africa has been a matter for discussion for more than 80 years. The apartheid years saw no progress towards any form of equitable national financial protection against health costs, but current proposals for the NHI are likely to be implemented in the near future, with a few aspects of the transitional process already in place.

The NHI seeks to remove the current-two-tiered health system in South Africa in an effort to pool all the country's health resources into one pool to allow for a wider distribution across the entire population. This single pool is expected to draw funds from general tax revenue as well as from a mandatory health insurance contribution in the form of a payroll tax.

Accredited public and private providers will be contracted by the NHI to deliver a comprehensive package of healthcare services. Individuals who wish to have additional health care benefits over and above this package will be able to obtain cover from private medical schemes, but it must be noted that the current tax subsidy for these schemes will no longer be available.

The primary objective of the proposed NHI is universal coverage, whereby all citizens have access to quality, essential health services and everyone has financial protection against

health costs. The key principles of universal coverage are that individuals contribute according to their ability-to-pay and benefit according to their need for health care. If South Africa is to achieve universal coverage, policy decisions need to be aimed at ensuring that a higher proportion of the population is protected against health care costs and the access to health care is improved.

The NHI will be phased in over a period of fourteen years and will be guided by principles of equity, efficiency, effectiveness and appropriateness. The first five years of implementation have clear policy goals by which to measure progress.

Chapter Four will analyse the current mechanisms of health care financing employed in South Africa and the country's present health care expenditure. The chapter will also examine the health care financing concepts of revenue collection, pooling, and purchasing. The final aspect of the chapter will be a discussion of the mandatory contribution system.

Chapter Four: Health care financing

4.1 Introduction

This chapter commences with a review of the present health care expenditure in South Africa and how this spending is currently funded. In order to analyse the practicality and feasibility of the NHI it is necessary to have a good understanding of health care financing principles and thus an explanation of revenue collection, pooling, and purchasing will be provided.

4.2 Current funding and expenditure in South Africa

The DOH (2011) notes that the three main sources from which South Africa's health care expenditure is derived include:

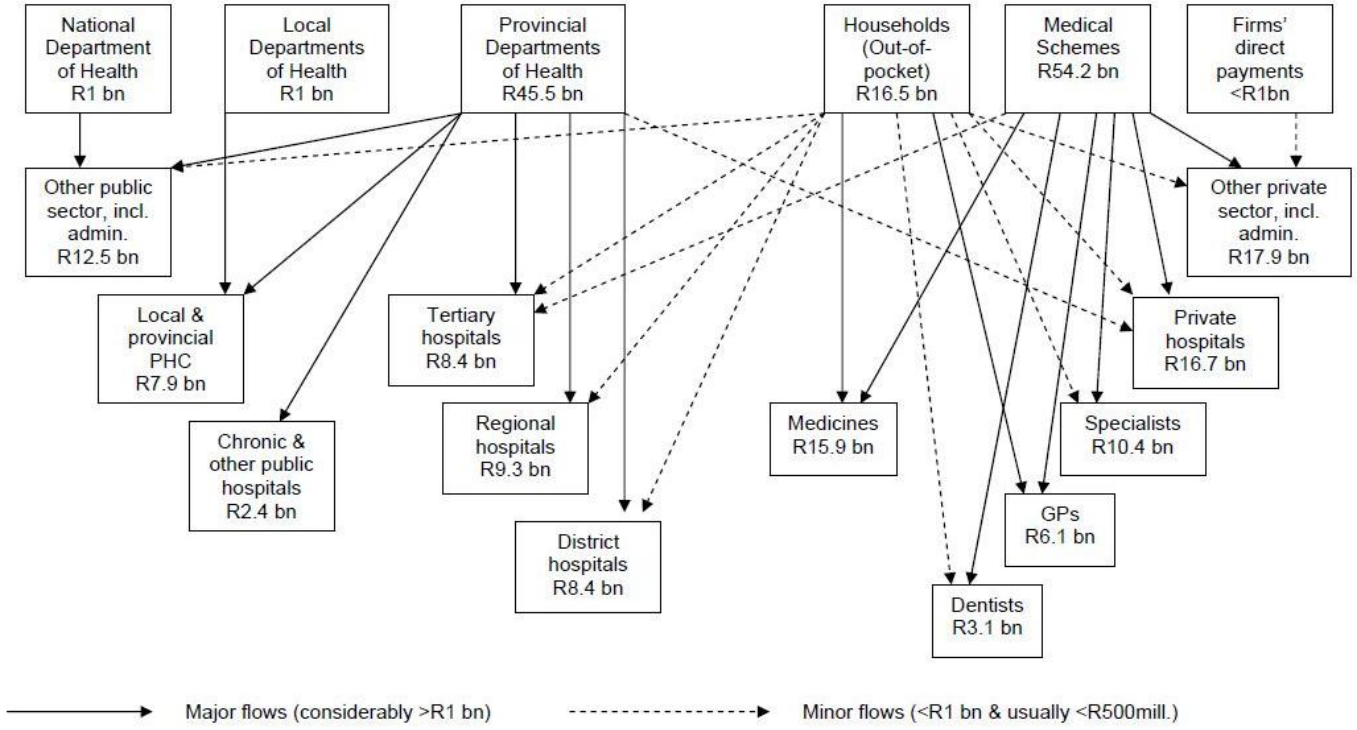
- Public sector expenditures financed out of general revenue;
- Private sector expenditures funded through medical schemes; and
- Out-of-pocket payments.

According to the DOH (2011), the current health care expenditure in South Africa amounts to 8.5% of Gross Domestic Product. The World Health Organisation recommends that countries spend at least 5% of their GDP on health care (DOH: 2011). Schieber, Baeza, Kress and Maier (2006) report that the average low-income country spends 4.7% of its GDP on health services, while middle-income and high-income countries spend 5.8% and 7.7% of their GDP on health care respectively. It is clear that South Africa already spends more than the WHO suggests and that the country's health care expenditure is on par with and in some cases higher than the world's wealthiest nations. It is, however, a reality that the health status indicators in South Africa are far worse than those in other upper-middle income countries (ANC: 2010). Thus, McIntyre *et al* (2007) argue that the key challenge facing South Africa's health sector is not a lack of financial resources, but rather a strong necessity to use the existing resources more efficiently and equitably.

The DOH (2011)) notes that the 8.5% of GDP that is spent on health care is split as to 4.2% in the private sector and 4.3% in the public sector. A staggering statistic is that the 4.2% in the private sector only covers 16.2% of the population, the majority of whom are covered by medical schemes, whilst the remaining 4.3% is spent on 84% of the population who mainly

use public health care facilities (DOH: 2011). This expenditure is financed 40% via public sector financing intermediaries (general tax revenue) and 60% through private intermediaries (McIntyre *et al*: 2007). McIntyre *et* al note that included in the private sources are out-of-pocket payments which account for 14% of total health care financing. Figure 2 below demonstrates the distribution and sourcing of health care expenditure in South Africa in 2005.

Figure 2: Health Care Expenditure in South Africa, 2005



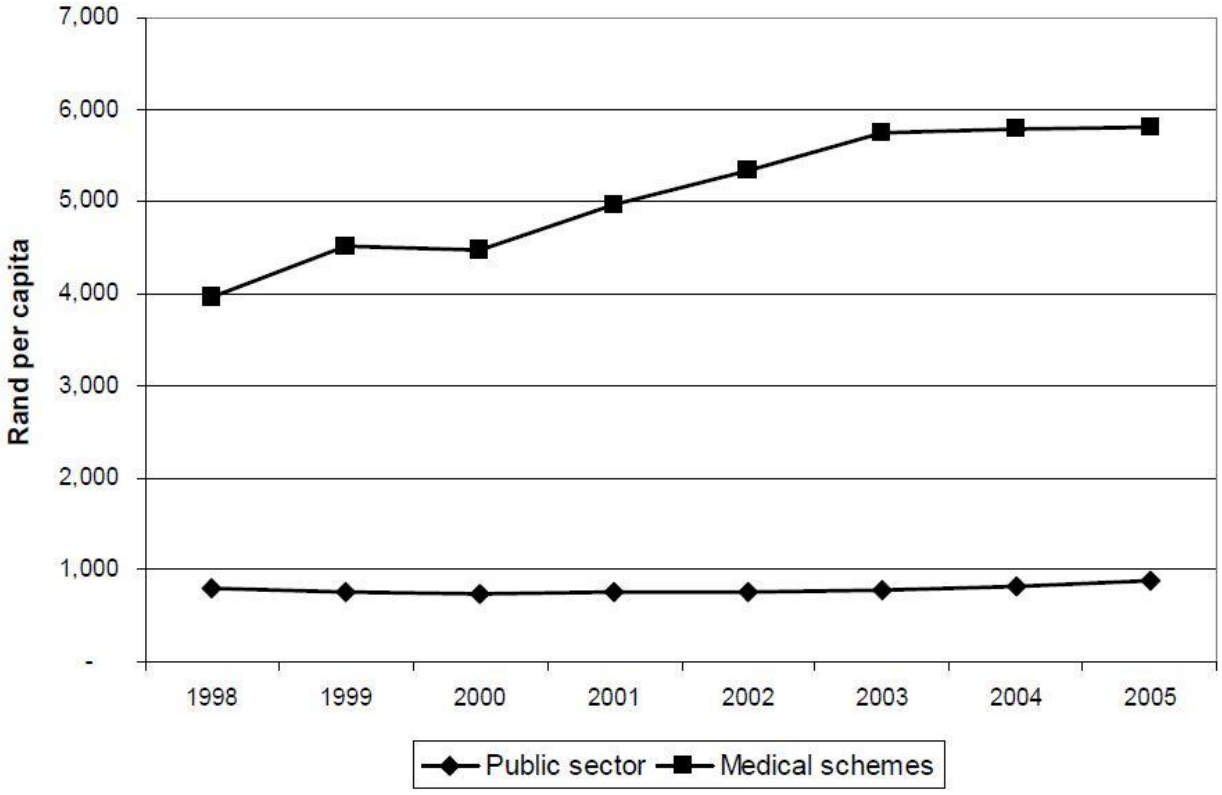
Source: McIntyre *et al* (2007)

In the decade following the end of apartheid, there was very limited real growth in public health expenditure, largely as a result of the Growth Employment and Redistribution policy previously mentioned (McIntyre *et al*: 2007). McIntyre *et al* reveal that in striking contrast to the public sector, expenditure in the private sector has continued to increase on an annual basis at rates far exceeding the inflation rate. As expenditure increases, so do the contribution rates that are charged by medical schemes and membership to these schemes has become increasingly unaffordable for South Africans. According to the Council for Medical Schemes (2006), in the early 1990s 6.5 million people were covered by medical schemes and in 2005

this number had only reached 6.9 million. In real terms this is a reduction because in 1992 17% of the population were members and in 2005 only 14.8% of South Africans were covered by medical schemes. McIntyre *et al* highlight the fact that while the quantity of financial and human resources available to medical scheme members continues to increase, the proportion of the population served by these schemes is in decline.

In 2005, over R8000 was spent by medical schemes per beneficiary, while less than R1200 was spent on public sector health services per person who is not a member of a medical scheme (McIntyre *et al*: 2007). Figure 3 below illustrates how medical scheme expenditure per person has been increasing rapidly in real terms whilst public sector spending has remained constant.

Figure 3: Trends in real per capita health care expenditure in public sector and medical schemes (2000 base year); 1998-2005



Source: McIntyre *et al* (2007)

According to Van den Heever (2007), three large hospital groups own 84% of all private hospital beds and there is a clear indication that these companies are using their oligopoly power to charge excessively high prices instead of engaging in price competition with one

another. The fee-for-service method of reimbursing private hospitals and practitioners has contributed to the rise in utilisation as earnings are directly related to the volume of work performed (McIntyre *et al*: 2007). According to McIntyre *et al* owners of private hospitals purchase expensive high-technology equipment and then put substantial pressure on personnel to use the equipment to earn more revenue for the hospital. Furthermore, private hospital owners offer private specialists rent-free or subsidised consulting rooms if they meet targets for use of hospital facilities. This practice has led to higher levels of hospitalisation, longer periods of admission and increased use of diagnostic procedures. The fee-for-service method encourages health care professionals to waste valuable resources as they know that they will be reimbursed for any costs they might incur and can possibly receive benefits for high levels of equipment utilisation.

Positive legislation has been introduced which requires pharmacists to offer patients a generic substitute for any medicine prescribed, unless the prescribing doctor explicitly states that the medicine cannot be substituted (McIntyre *et al*: 2007). This new law resulted in the use of generic medicines increasing by 14% between 2003 and 2004. Another piece of encouraging legislation is a law which provides that manufactures of medicines must sell at the same price to all purchasers. In the past, manufactures would grant enormous discounts (up to 80%) to private hospitals to ensure that their products were included in the hospital's list of prescribed medicines. To recover the costs of these discounts the manufactures had to charge higher prices to small pharmacies, especially those in rural areas. A major problem of this practice was that the discounts were never passed on to any consumers.

In the private sector, non-health care items such as administration, broker fees and approving requests for a member to be admitted to hospital accounted for R7.8 billion in 2005 (Council for Medical Schemes: 2006). The shocking statistic is that more is spent on these activities than is spent on general practitioners and dentists combined, or on medicines. It is clear that medical scheme contributions and expenditure are rapidly spiralling and this is largely a result of the stagnation in the number of members as more South Africans can no longer afford the high premiums associated with these schemes (McIntyre *et al*: 2007).

According to McIntyre *et al* (2007), there is a strong argument that the resources contributed to medical schemes could be used more efficiently and that if efficiency gains were achieved, pre-payment cover may be affordable to a larger proportion of the population. It is clear that there is a need for South Africa to move away from a two-tiered system of health care

financing which includes a private sector containing supplier-induced demand toward a system of cross-subsidisation between healthy, younger and wealthier population groups and the sick, elderly and poorer groups.

4.3 Revenue collection

McIntyre (2007) notes that revenue collection refers to the sources of health care funding contributions and the entity chosen to collect them. The main issue surrounding the sources of funds is the balance between external and domestic sources and, within domestic sources, between commercial companies (or employers) and individuals (or households). The entity collecting the funds could be either the government or a private organisation (McIntyre: 2007).

Within any nation, all domestic funding for health care ultimately arises from two main sources, namely companies and individuals (or households), irrespective of whether it is sourced through general tax payments, health insurance or direct out-of-pocket payments (McIntyre: 2007). In most tax categories, including personal income taxes, payroll taxes, VAT, customs and excises taxes, and the fuel levy, it is reasonable to allocate the full tax burden to the consumer or individual (McIntyre *et al*: 2007). According to McGrath, Janisch and Horner (n.d.), there is debate on how to treat corporate tax as the burden could either be borne by shareholders or it is shifted to consumers by increased commodity prices.

In 2000, the top income decile paid an average of 26.8% of their income as personal income tax while the second highest income group paid 23% (McIntyre *et al*: 2007). The lowest two income groups paid 0% for the same period. The poorest decile contributes almost 9% of income to VAT, compared to only 6.6% for the richest decile. With regard to excise taxes on demerit goods such as tobacco and alcohol, the poorest decile pays 0.8% of their income while the richest decile pays 0.2%. When it comes to the fuel levy, the poorest decile pays about 2.2% of their income, whereas the richest decile pays 2.7%. It would thus appear that the taxes that affect the poor the most are VAT, excise taxes and the fuel levy, while the rich are most concerned by personal income tax and to some extent VAT. McIntyre (2007) notes that VAT is levied at a flat rate as opposed to on a progressive scale and thus poorer groups pay a higher proportion of their income than richer households. To protect the poor, many basic foodstuffs and paraffin are exempt from VAT in South Africa.

McIntyre (2007) highlights an important issue for low- and middle-income countries which is the balance between domestic and external resources for health care funding; South Africa, however, does not rely on other countries for health care financing and draws its funds almost entirely from domestic sources. For countries which do depend on donor funding for health care there is much concern about the long-term stability and sustainability of such financing.

There are two options for how contributions to health care financing can be made (McIntyre: 2007):

- An out-of-pocket mechanism, where
    - The user pays a fee at the time of receiving the health care service; and
- A prepayment mechanism, where
    - The user contributes to the financing of health care through regular social health insurance or tax payments.

According to McIntyre there is strong evidence of the impoverishing effects of out-of-pocket payments and preference should be given to prepayment mechanisms. It is common for those who need health care to have to borrow money from friends, family or other sources or to sell assets such as livestock because they do not have ready cash. The World Health Organisation (2005) estimates that each year 100 million people around the world become impoverished and a further 150 million face rigorous financial hardship as a direct result of health care expenses. In an effort to relieve the drastic effects of out-of-pocket payments on households, there are no user fees charged at the primary health care level in public facilities in South Africa (McIntyre: 2007). Where a prepayment mechanism is in place, there are two main forms of funding; tax revenue and health insurance.

Mandatory health insurance contributions can either be a fixed proportion of payroll earnings on a progressive scale or there can be a ceiling on contributions where high-income earners have to make a fixed payment rather than an amount calculated as a percentage of their earnings (McIntyre: 2007). The ceiling means that the wealthiest portion of the population contributes in a more equitable manner with regard to the benefit they will derive from the system, but it reduces the level of cross-subsidisation of the poor by the rich.

The potential for health insurance to generate revenue is constrained by the income level and distribution of income within a country; two factors that affect the ability of individuals to make contributions to health insurance (McIntyre: 2007). McIntyre notes that the size of the

formal sector also has a bearing on the revenue-generating potential of health insurance. The importance of the formal sector is that it is the main source of revenue in the early stages of implementation of a national health insurance scheme. According to McIntyre, concerns raised by employers and trade unions about mandatory insurance schemes increasing the cost of labour and thus escalating the problem of unemployed are unjustified. This is because the entire cost of the contribution is borne by the employee as health insurance is seen as part of the remuneration package and it is a form of forced savings which ultimately translate into health benefits for the employees and their families.

A further constraint on revenue collection for health insurance noted by McIntyre (2007) is the generally high administrative costs involved in actually collecting the revenue. However, McIntyre points out that a public mandatory health insurance can avoid the costs of marketing a product and does not need to incur substantial actuarial costs in determining risk-rated premiums.

According to McIntyre (2007) the type of entity performing the collection function can have an impact on the proportion of collectable revenue that actually is collected. In countries where the government is not seen as accountable to the population or has not gained its confidence, tax evasion can be high. If the government does not have widespread support or if citizens do not trust the government to act in their best interests, it may be preferable for a parastatal or a private not-for-profit organisation to manage the mandatory insurance.

4.4 Pooling of funds

Kutzin (2001) describes the fund pooling function of health care financing as "the accumulation of prepaid health care revenues on behalf of a population". According to McIntyre (2007), health care costs are unpredictable because people do not know when they are going to fall ill, what health care they will require and what this health care will cost. The reality is that most individuals are unable to pay for these unexpected costs at any given time through out-of-pocket payments. McIntyre acknowledges that it is difficult to predict an individual's future health care costs, but notes that by drawing on epidemiological and actuarial data, it is possible to estimate the probable future health care needs of a group. This is the key principle behind risk pooling; people contribute on a regular basis to a pooled fund so that in the event that they do fall ill, the fund will cover their health care costs. McIntyre

suggests that another way of viewing the principle is that at any point in time, the healthy member of the pool are paying for the health care costs of those who are ill.

It should be noted that the larger the risk-pooling group, the easier it is to predict the overall require health care expenditure. Furthermore, in countries where health care is financed through mandatory health insurance, the risk is shared across the entire population and thus maximum risk pooling is achieved. According to McIntyre (2007), voluntary health insurance schemes are faced with the problem of adverse selection, whereby those with the greatest risk of falling ill are actually the most likely to seek insurance cover, further limiting the potential for cross-subsidisation from the healthy to the ill. An additional factor which reduces the potential for cross-subsidies is that medical schemes make efforts to attract the healthiest individuals and set very high risk-rated contributions or exclude coverage of pre-existing conditions. McIntyre remarks that the overall result of these practices is that there is drastic limitation of cross-subsidies in the overall health system, with the healthy and wealthy being members of medical schemes and the ill and poor being left to rely on publicly funded health services.

A further aspect of risk pooling is the need to ensure that resources are distributed in accordance with health care needs and the risk of future health care costs. In South Africa, the pooling organisation is the National Treasury which is responsible for the allocation of funds to each of the national level Departments, the nine provinces, and local governments. These allocations are based on formulae which have been developed by taking into consideration the relative need for services in each sector. In addition to the allowances from the national level, provinces generate their own revenue through gambling taxes, liquor licences, motor vehicle licenses, user fees, and fines. Local governments also generate their own revenue through property rates and utility sales.

McIntyre (2007) notes that the relatively well-equipped health facilities tend to be urban areas and that historical budgeting approaches result in urban populations capturing a disproportionate share of public health care resources. Rice and Smith (2002) suggest that risk-adjusted resource allocation methods are designed to redress the geographic disparities in health care resources and have a goal of promoting equal access to health care on the basis of need. Rice and Smith offer the following indicators of need for health services in a specific geographic area:

- *Population size;*

- *Demographic composition;*
- *Levels of ill-health; and*
- *Socio-economic status.*

With regard to the private sector, in 2005 there were 131 registered medical schemes collecting and pooling revenue and a total of 6.9 million beneficiaries (McIntyre *et al*: 2007). According to McIntyre *et al* this large number of schemes in relation to the number of beneficiaries significantly limits the effectiveness of risk pooling. It is important to note that within each medical scheme there are many different benefit packages which further reduce the effectiveness of risk pooling.

Prior to the Medical Schemes Act (Act No. 131 of 1998), medical schemes were permitted to discriminate against the elderly and chronically ill through denial of membership to particular applicants. The aim of the Medical Schemes Act was to abolish these discriminatory practices and to ensure open access to medical scheme coverage, however, according to McIntyre *et al* (2007), practice shows that there is very little cross-subsidy from the healthy to the sick. McIntyre *et al* are of the belief that due to the small risk pools and the lack of income cross-subsidies in South Africa, the potential of medical schemes to contribute to equitable health financing is relatively constrained.

Rice and Smith (2002) suggest that resource allocation can be equitable through what is commonly referred to as "risk equalization", a process which is often adopted by mandatory health insurance schemes made up of several small funds. The risk profile of each scheme is assessed using factors such as age, gender, and the proportion of members with chronic illnesses and disabilities. This risk profile structure of the scheme is used to calculate a risk-adjusted capitation amount equivalent to the average sum per member required to cover likely health care costs for a standard benefit package. According to Rice and Smith, the risk-adjusted amount per capita is multiplied by the number of members in the scheme corresponding to each type of risk profile in order to determine the total amount to be allocated to each scheme. Thus, risk-adjusted capitation is used to allocate all resources among the different schemes. McIntyre (2007) believes that these risk-adjustment mechanisms allow for cross-subsidies between individual schemes, thereby consolidating the risk pool. In some countries, such as the Netherlands, mandatory insurance contributions are collected centrally and individual insurance schemes undertake purchasing. Purchasing is discussed next.

4.5 Purchasing

Kutzin (2001) defines purchasing in the health financing context as "the transfer of pooled resources to service provides on behalf of the population for which the funds were pooled." The key issues in the purchasing function include the choice of benefit package to which beneficiaries would be entitled and the choice of mechanism for paying the providers of health care.

It needs to be decided whether the benefit package will include primary care or low frequency, high cost services such as hospital care. Alternatively it could cover all types of health care. McIntyre (2007) suggests that in countries with high poverty levels, essential primary health care services should be covered. The present paper has already noted that primary health care is currently free of charge in South Africa and a list of the proposed comprehensive benefit package has previously been provided. According to Ros, Groenewegen and Delnoij (2000), if primary care services are not included in the package, patients tend to go directly to a hospital or specialist for a health problem that could have been dealt with at the primary care level at a much lower cost. Thus, primary health care providers act as gatekeepers to hospital care and are a useful way of containing costs.

Kutzin (2001) supports an active purchasing approach which involves the purchaser routinely compiling and analysing relevant epidemiological information about the population and converting it into a benefit package that meets the health care needs of the population. Ultimately, the design of a benefit package depends on what people in a given country can afford.

Once the benefit package has been determined it is necessary to decided on the types of providers that beneficiaries can use to secure services. McIntyre (2007) notes that the purchaser may stipulate that the full costs of services included in the package are only covered if they are provided by a public sector facility. This is the case in systems where all tax resources are channelled to public facilities. Alternatively, the health insurance scheme could stipulate that beneficiaries will only be reimbursed for health care costs if they have used accredited providers (Normand & Weber: 1994). This accreditation is usually based on the provider meeting criteria that ensure adequate quality of care, an appropriate range of services and a willingness to charge rates that provide value for money.

Over and above the accreditation, Maynard (1994) recommends that contracts are drawn up between the purchaser and the provider that specify the types of service that may be provided to beneficiaries, the amount of money the provider will receive for services, the mechanism for paying the provider and the quality and other performance requirements related to the service provided. Normand and Weber (1994) emphasize the importance of ensuring quality health care access, especially when mandatory insurance is being introduced in the face of opposition. Furthermore, it is necessary to ensure that adequate service delivery infrastructure is in place to ensure that the entitlements specified in the benefit package can actually be realized.

McIntyre (2007) notes that payments to providers are either paid prospectively or retrospectively. These are the main forms of provider payment mechanisms:

- *To individual providers:*
    - ***Salary:*** *determined prospectively, paid retrospectively;*
    - ***Fee for service:*** *determined prospectively, paid retrospectively;*
    - ***Capitation*** *(i.e. a flat payment per person cover, who is then entitled to use all services covered in the benefit package offered by that provider): determined prospectively, paid prospectively*
- *To facilities:*
    - ***Budget allocations****: determined prospectively, paid prospectively;*
    - ***Fee for service****: determined prospectively, paid retrospectively;*
    - ***Per diem*** *(a flat payment per day of hospitalization): determined prospectively, paid retrospectively;*
    - ***Case-based fee*** *(a flat payment per treatment package, such as for tuberculosis): determined prospectively, paid retrospectively.*

It has been previously highlighted how fee for service mechanisms encourage wasteful use of resources, but it should also be noted that the capitation method can result in providers trying to attract only low-risk patients and providers also have an incentive for offering a poor service.

Normand and Weber (1994) warn that the more fragmented a health care financing system is and the greater the number of independent purchasers there are, the more difficult it is to exert pressure on providers to contain costs. In this sort of environment providers can simply refuse to provide service to beneficiaries of purchases who attempt to limit their profit margins. It is thus recommended that there is only one large purchaser which can use its purchasing power to negotiate lower fees with providers and to impose global caps on reimbursement claims.

4.6 Conclusion

Despite very poor health outcomes, South Africa is actually currently spending a higher proportion of its GDP on health care expenses than most high-income countries. It would appear that there is not a lack of financial resources in the country, but instead an inequitable distribution of health care facilities and services. Over the past decade there have been rapid increases in medical scheme contributions and expenditure whilst public spending on health care has remained constant in real terms. An oligopoly exists within the private health sector and there is wasteful use of resources as a result of the fee-for-service mechanism of provider payment.

It is clear that an out-of-pocket payment mechanism can have impoverishing effects on society and many authors are in favour of pre-payment method. There is a strong belief that a parastatal would be preferred over government as the type of organisation for the implementation of NHI. Citizens might have concern over a mandatory contribution that goes to a government which has a poor reputation for service delivery.

Risk-pooling is used to counter the effects of unpredictable and high costs of health care. The larger the risk pool, the easier it is to predict the overall health costs for a group. If the goal is to achieve universal coverage, a mandatory contribution system allows for the maximisation of risk-pooling as it spreads risk over the entire population. Current practices by medical schemes have resulted in very fragmented risk pools with very little cross-subsidisation between the rich and the poor or the healthy and the ill.

With regard to the purchasing function, it would appear that a single powerful purchaser is the most efficient. A benefit package needs to be established which best suits the health care needs of the population. It is important to ensure that providers are carefully selected and that they are accredited through the use of strict quality assuring criteria. The utilization of contracts between the purchaser and the providers is also beneficial. The next chapter will analyse the feasibility of the proposed NHI, taking into account the estimated costs and the relevant tax implications of such a system.

Chapter Five: Feasibility in a South African context

5.1 Introduction

The present paper has thus far discussed the nature of the current problems in the South African health care system and the roots of the obvious inequalities embedded in its two-tiered structure. In addition, a brief history of health reform in the country has been presented and the current proposal of NHI by the ruling party has been outlined. Furthermore, an explanation of various health care financing principles has been provided. All sources appear to agree that the status quo holds excessive inefficiency and inequality and that there is a desperate need for an overhaul of the health care system. However, there is much deliberation over whether the proposed NHI is actually a feasible option for South Africa. The aim of this chapter is to explore both sides of this feasibility debate by first analysing the estimated costs of National Health Insurance and then considering the relevant tax implications.

5.2 Estimating the cost of National Health Insurance

There is one element of the discussion which all parties agree on and that is the fact that it is impossible to model with 100 % accuracy the precise resource requirements of any future health care system. However, each source believes that their model and figures provide a good indication of the expected magnitude of the estimated resource requirements.

The costing model used by the DOH (2011) is the same approach adopted by McIntyre (2010b) and is as follows:

Total expenditure = *user population* **x** *service utilisation rates* **x** *unit costs*

According to the DOH (2011), the model takes into account the population size and how it will grow over time as well as the age and gender composition of the group. Furthermore, it factors in the frequency of use of various health services for the different groups. McIntyre (2010b) notes that young children, the elderly, and women of childbearing age have particularly different health care requirements to the rest of the population. The final element of the model considers the costs of provision for each type of health service. Both the DOH and McIntyre based these costs on the current costs of public sector services and claim to have taken into account the need to dramatically improve resourcing. The DOH states that the

intention is that the NHI benefits will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw on their NHI entitlements.

The rationale provided by McIntyre (2010b) for using the public sector framework as the basis for modelling the costs of a universal coverage system is that the NHI will cover a comprehensive package of services that includes primary health care services as well as hospital inpatient and outpatient care. McIntyre believes that the proposed benefit package will thus be more similar to the current public sector framework than the current medical scheme framework. The public sector currently operates on a 'negative list' basis which means that they cover everything except certain services, whereas the medical scheme packages state a very explicit 'positive list' of what *is* actually covered. A further reason offered by McIntyre for using the public sector framework is that only 16% of the population is covered by medical schemes and thus a model based on the medical scheme framework would not be representative of all South Africans.

Econex (2010) has strong criticism for the model employed by McIntyre (2010b) and the DOH (2011). Although Econex acknowledges that a demand-based estimate is the most appropriate method for estimating the overall cost of a health care system, it regards their work as simply a costing of public care if the whole population were to be covered by the pubic sector and notes that there is no real indication that improving service levels or quality was really taken into account. Econex is also of the opinion that the McIntyre and DOH estimates do not actually provide for the comprehensive package proposed by the NHI plan and remarks that the best way to interpret their costing is as a low estimate of what a better funded public health service would cost, using existing cost structures in the public sector. Essentially, Econex believes that McIntyre and the DOH have merely attempted to cost the required public sector spending if those presently covered by private schemes were also to be covered by a redefined public sector.

There is further concern over possible under-estimation of the necessary administration costs for a system such as the NHI. McIntyre (2010b) estimates these costs to be between 2% and 5% of the overall costs of universal coverage, while the ANC (2010) opts for an amount in the range of 2.5% and 2.8% of total expenditure. According to van den Heever (2010), no rationale is provided for this low estimate despite the fact that the NHI is designated to perform many onerous functions for which no private or public sector equivalent exists in

South Africa. The Council for Medical Schemes (2010) reveals that the medical scheme with the lowest administration costs is the Government Employees Medical Scheme (GEMS) at 6%. Clearly the NHI would be a far more complex organisation than GEMS and it is expected that it would involve more intricate administration. Also, GEMS uses a fee-for-service system which is less admin intensive than the proposed capitation method of payment under NHI. According to the South African Revenue Services (2011), the Unemployment Insurance Fund's administration costs equal 25% of its total costs. This is clear evidence that it is highly probable that the administration costs for the proposed NHI have been underestimated. Van den Heever also raises concerns over the availability of the necessary skills in South Africa to manage and operate such an organisation.

Table 2: Estimated cost of health care delivery under the NHI proposal

	R' Billion	
Source	**2012**	**2025**
ANC: 2010	128	376
McIntyre: 2010b	196	394
DOH: 2011	125	256

Table 2 above shows the estimated cost of health care if the NHI were to be implemented. It should be noted that all figures are shown in real terms (i.e. these are the values in real 2010 financial terms). The most striking observation is the R120 billion decrease in the government's estimate of the 2025 expenditure from the ANC's discussion document figure of R376 billion to the DOH's green paper amount of R256 billion. There is no explanation as to why only a year later there has been such a drastic alternation to the estimate. In all instances, McIntyre estimates the costs to be higher than what the ruling party has put forward.

The estimations shown in Table 2 by ANC (2010) are based on the NHI proposal which suggests an increase in public health expenditure from 4.2% of GDP to 8.5% by 2025. This target percentage of GDP corresponds with existing estimates of total expenditure on health care in South Africa (i.e. private and public combined). It is the belief of the ANC that the equity objective can be achieved through creating targets such as this. Van den Heever (2010) argues that this is not really a costing analysis at all, but rather a phased budget proposal fitted to a timeline from 2012 to 2025. According to van den Heever it is merely a

coincidence that the ANC's projected figure for 2025 is so close to the cost estimate made by McIntyre (2010). In addition, van den Heever is concerned about the fact that the ANC has made estimates to fit within a set percentage of GDP and argues that the method has no measurable social outcomes. Furthermore, van den Heever believes that the figures projected by McIntyre are underestimated as they are based on the public sector framework and do not take into the account the additional cost of contracting the private sector. Econex (2010) expects there to be a strong preference for private hospitals and unconstrained demand for general practitioners would also add costs. Econex also warns that if costs were to be cut to match the public sector framework, the quality of health care provision would be in danger and skills flight of medical personnel would be accelerated.

Bearing in mind that it is highly likely that the proposed figures are underestimates of the actual resources required to implement an NHI offering a comprehensive benefit package, it should be noted that according to van den Heever (2010), no precedent can be found for a developing country increasing its pubic health expenditure to 8.5% of GDP. Van den Heever also highlights the fact that only two developed countries spend 8% or above. A further point made is that, despite having NHI, total public expenditure is only 3.6% and 3.7% of GDP for South Korea and Taiwan respectively. This is made possible by their considerable income and favourable employment levels. The next section will discuss the affordability of the NHI proposal with regard to the fiscal resources available in South Africa.

5.4 Taxation implications

According to McIntyre (2007), the extent to which a general tax burden can be imposed on a country depends, among other things, on the size of the formal sector, the extent to which the government wishes to encourage business investment, the poverty level, and the distribution of income among the population. McIntyre cautions any government which is considering introducing a mandatory health insurance scheme to first determine whether companies and households can bear this additional financial burden. Furthermore, McIntyre notes that there is little room for increases in tax rates as the highest marginal income tax rate is within the 20-40% range already.

It is the view of the DOH (2011) that the current total health care expenditure in South Africa is sufficient to cover every citizen, but believes that it is not apportioned equally. Thus, in the

opinion of the DOH, the NHI can be funded by only slightly increasing taxation if all the resources are pooled and expenditure on health care is performed by one single purchaser.

The South African government currently devotes 11.5% of its total budget to health care expenditure. According to the Organisation of African Unity (2001), the African heads of state committed themselves at a meeting in Abuja in 2001 to allocate a minimum of 15% of total government expenditure to health care. McIntyre (2007) acknowledges that most low- and middle-income countries cannot increase government spending without increasing tax revenue, however McIntyre argues that most of these countries can increase the percentage of total government revenue assigned to the health sector. McIntyre (2010) believes that universal coverage could be funded almost entirely by increasing the health budget's share of the total budget to 15%.

Without increasing the budget allocation to 15%, McIntyre (2010) estimates that taxes would need to increase to rates that would see the highest tax group paying up to 45% of their taxable income. Grant Thornton (2010) agrees with McIntyre's short-term estimate, but predicts that with the NHI's funding requirements this same group could be taxed at 55% by 2025. Grant Thornton believes that this is a matter of great concern as South Africa's economy is most reliant on the individuals in this taxpayer group and suggests that these people are likely to relocate to other countries should they be faced with higher tax rates. A factor which Grant Thornton considers to be instrumental in this anticipated skills flight is the fact that the average top marginal tax rate globally is around 29%.

Grant Thornton (2010) also warns against increasing the current company tax rate of 28% as this would most likely discourage foreign investment. An option which Grant Thornton believes could be effective is an increase in VAT, allocated exclusively to the NHI. Grant Thornton does however anticipate widespread disapproval of the suggestion, especially from trade unions. McIntyre (2007) explains that VAT is a very regressive form of taxation because it is levied at a flat rate and so poorer households pay a higher proportion of their income than richer households. McIntyre suggests that a way to make VAT less regressive is to expand the list of basic goods that are exempt from VAT and to apply a higher rate of VAT on luxury goods. The purpose of targeting VAT for the increase is to spread the additional revenue collection over a larger number of people and so efforts to make VAT less regressive would be counter-intuitive to this. Grant Thornton is in strong favour of widening

the tax base to include more individual taxpayers as opposed to increasing the tax rate for those in the small tax base.

The idea of allocating a tax exclusively to a specific usage is referred to as an 'earmarked tax'. McIntyre (2007) believes that earmarked taxes bring forth greater willingness to pay taxes as taxpayers know exactly what the revenue collected is being used for and are aware of their entitlements to benefits. McIntyre suggests that taxpayers are often not sure what the revenue will be used for and notes that the problem is particularly acute in countries where corruption is rife. A problem highlighted by McIntyre in countries which have introduced earmarked taxes is that the government reduces the general budget allocation to the relevant sector as they believe that the dedicated tax supposed to fund it. In these countries it is often the case that the dedicated tax is offset entirely by an equal reduction in the general tax-funded proportion of the budget allocation to health sector. Van den Heever (2010) finds earmarked contributions to be appropriate where risk pooling is the principal goal, but believes that ordinary taxation is more suitable in situations such as the NHI where vertical subsidies are required and there is significant income cross-subsidisation. Taxpayers contributing to the general tax pool believe that they will at least benefit in some way or another either through road usage or emergency services for example. For this reason, van den Heever is of the opinion that a mandatory tax contribution for the NHI would merely be a complication of the existing general tax system.

A final point to consider with regard to taxation in the realm of health care is the tax subsidy currently granted in the form of a deduction to medical scheme contributors. According to McIntyre (2007) the total value of the subsidy amounted to R10.1 billion in 2005. McIntyre notes that in 2005 less than 15% of the population was covered by medical schemes, yet this subsidy was equivalent to more than 20% of the government health budget in that year. McIntyre questions the legitimacy of granting a deduction to individuals who contribute to private voluntary health insurance schemes. Those who are in favour of the tax subsidy argue that it makes private health insurance more affordable by a greater proportion of the population. Furthermore, supporters of the tax subsidy declare that the subsidy is beneficial to government as limited public resources can be devoted to the population groups who are solely dependent on government services. McIntyre argues that the amount of tax revenue lost through these allowable deductions actually exceeds the general tax revenue that would be devoted to direct public provision of health care for this group. McIntyre has strong criticism of the tax subsidy and views it as "a policy of distributing scarce tax resources to

subsidise the purchase of private health insurance for the wealthiest in society". Grant Thornton (2010) believes that this tax deduction will no longer be allowable with the introduction of a mandatory contribution system for health care.

5.5 Conclusion

The ruling party believes that South Africa currently has the necessary financial resources to implement the proposed NHI. This belief is based on the assumption that all South Africans will receive equal and quality health care if the current total health care expenditure of 8.5% of GDP is distributed evenly over the entire population. Those who disagree with this feasibility judgement are concerned that the proposed cost of providing universal coverage and a comprehensive benefit package for all South Africans has been severely underestimated as it is based on the current public sector framework. Furthermore, they believe that the costs of increasing quality levels, contracting the private sector, offering a broad range of benefits, and requiring no out-of-pocket payments have not been fully budgeted for. A particular cause for concern is what would appear to be gross underestimation of the administration costs required in a system such as the NHI. A further aspect of the government's budgeting process which has stemmed debate is the idea of targeting a specific percentage of GDP as opposed to actual health outcomes.

The South African government made a commitment in 2001 to allocate 15% of its total budget to health care, yet this figure is currently at 11.5%. It is estimated that in order to fund the NHI, taxation in the highest marginal bracket would need to increase to a rate of 45% in the short-term and eventually to 55% in the long-term. There is concern that increasing personal income tax to these levels could spark skills flight, while increasing company tax could result in decreased foreign investment. It is expected that increasing VAT with an earmarked tax for health care would ignite disapproval from the trade unions, but it is a way of increasing taxation in the country in a manner which targets all South Africans. Those in favour of earmarked taxation claim that taxpayers are more willing to pay this form of tax as the taxpayer is aware of their entitlement to benefits. There are sources, however, which propose that dedicated taxes complicate the tax system and that general taxation is better. A further tax implication is that it is expected that the current tax deduction allowed to medical scheme contributors is likely to fall away with the introduction of NHI. Some authors are in favour of the removal of this allowance because the subsidy per scheme member is more than

the government medical expenditure per citizen and thus the state is simply subsidising private health care.

When taking into account the estimated costs of financing a comprehensive national health insurance scheme such as the one proposed by the NHI and the already strained and relatively small tax base of the country it would appear that the proposal is not currently feasible in a South African context. The final chapter will offer recommendations with regard to the feasibility of the implementation of NHI and the country's fiscal capabilities. Furthermore the chapter will highlight limitations of the current research and present opportunities for further research.

Chapter Six: Recommendations, limitations and opportunities for further research

6.1 Recommendations

The South African health care system is in clear need of an overhaul and there are massive inequalities with regard to the distribution of income and resources between different groups of people in the country. The present paper has revealed some of the roots of these disparities and how they translate to a current health care system which is plagued with problems. The purpose of this research is to evaluate the feasibility of the proposed NHI, taking into consideration the limited fiscal resources available in South Africa. After an analysis of the aims and objectives of the NHI, the estimated costs of universal coverage and the relevant tax implications its implementation would have, the final recommendation of this paper is not to implement the NHI as currently proposed. Instead, further research needs to be conducted into finding a solution to the inequalities in the provision health care so that every South African citizen can each their constitutional right to health care.

6.2 Limitations

The first limitation of this research is the fact that there is no primary data collection. The present paper is compiled by analysing and interpreting the research of other authors and involves no actual feasibility estimations. Thus, the judgement of feasibility is based on what others authors have purported.

A further limitation of this research is the reality that the NHI is still a 'work-in-progress policy' and thus it is difficult to fully assess the feasibility as the final policy has not been fully legislated and put into practice. Feasibility assessments are an inherent part of the policy drafting process and it would be futile to only carry them out after a policy has been implemented, however the more developed a policy is, the easier it is assess its feasibility.

6.3 Opportunities for further research

The present paper considered the feasibility of a universal coverage system only. Research could be conducted which analyses the affordability of a two-tiered health system which involves a single compulsory medical insurance scheme for all those in the formal sector

above the tax threshold. The remainder of the population would still be solely reliant on the public sector for their health care requirements. Limited government resources would be servicing a smaller proportion of the population as a greater percentage of the population would be covered by the compulsory medical insurance scheme. The removal of the voluntary health insurance contribution tax subsidy could also result in more revenue for the public health sector. A single compulsory scheme would mean cost savings in terms of advertising and actuarial costs and the removal of duplicated administrative tasks. Furthermore, channelling sin tax collection to public health care provision could receive the support of those who pay personal income tax because this form of taxation is viewed as being regressive in nature. As the population becomes healthier it is likely that the formal sector will grow and more individuals would be contributing to the single mandatory health insurance scheme and can move away from being dependent on public health care facilities. The question of feasibility of such a system certainly generates an opportunity for further research.

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