Health care financing in South Africa: moving towards universal coverage

The World Health Organization (WHO) has encouraged countries to move towards achieving universal coverage – equity in access and guaranteed financial risk protection – where prepayment and pooling of resources and risks are the basic principles.

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Health care financing has recently received considerable research and policy attention in both developed and developing countries. One of the major issues is how to raise sufficient resources to finance health care needs for *all citizens.*[1,2] While this is fundamental, there are other important issues such as equity and efficiency in financing.[3] Internationally, it has been acknowledged that 'how health systems are financed largely determines whether people can obtain needed health care and whether they suffer financial hardship as a result of obtaining care'.[4] Also the 'design and implementation of an adequate health financing system are essential in the pursuit of universal coverage'.[4] In 2005 the World Health Organization (WHO) recognised that health financing systems in many countries, more so in developing countries, do not meet the prerequisites for universal coverage and therefore require further development in order to guarantee access to necessary services while also providing financial risk protection. In its 58th round of the World Health Assembly, member countries were encouraged to move towards achieving universal coverage. Universal coverage does not only relate to generation of health care funds but implies equity in access and guaranteed financial risk protection.[4-6] As it is the desire of all countries to move towards a system of universal coverage,[6] it is argued that 'irrespective of the source of financing for the health system selected, prepayment and pooling of resources and risks are basic principles in financial-risk protection'.[5] Further recognition of the importance of universal coverage for countries led to the WHO proposing the 2010 World Health Report to address financing for universal health coverage (UHC).

In South Africa, health care is financed through a combination of mechanisms. In 2005 for instance, allocations from general tax accounted for about 40%, private medical schemes about 45%, and out-of-pocket payments about 14% of total health care financing.[7,8] The burden of the various mechanisms of funding on households varies considerably. In moving towards universal coverage in this context, the enhancement of prepayment for health care in a manner that ensures that households finance health care according to ability to pay and where risks are pooled, is critical.[4] Universal coverage therefore requires considerable social solidarity, which is often enshrined in African cultures. Solidarity allows for cross-subsidisation of the poor by the rich (income cross-subsidy), and the sick by the healthy (risk cross-subsidy).

Universal coverage does not only relate to generation of health care funds but implies equity in access and guaranteed financial risk protection.

The macro-economic context of a country influences its ability and the need to achieve universal coverage. While South Africa contributes about half of the total economic output in sub-Saharan Africa,[9] its income inequality is not only one of the highest in the world but is worsening. The Gini index, a measure of income inequality, increased from 0.65 in the late 1990s to 0.72 in 2005/2006. (The closer the index is to one (1), the more unequal is the distribution of incomes. An index of one (1) implies that all incomes are commanded by the richest person in the economy. An index of zero (0) theoretically means that incomes are equalised among every citizen.) Expressed differently, the distribution of income in South Africa is such that the poorest 10% of the population shared only about R1.1 billion (representing about 0.1%

of total incomes) compared with R381 billion (representing 51%) by the top 10% of the population.[10,11] This alarming maldistribution of income is accompanied by high poverty and unemployment figures.[12] There are also correspondingly large inequalities in socio-economic status and access to social services between population groups, provinces and socio-economic groupings.[10,13] For example, relatively well-off provinces such as the Western Cape and Gauteng have the lowest poverty rate, highest medical scheme coverage rate and public health spending per capita, and better access to potable drinking water when compared with relatively poorer provinces.[13] These issues are often considered as social determinants of health as they have direct or indirect impacts on the overall health of the population.

In 2007 in Polokwane, the African National Congress (ANC) – the South African ruling party – committed itself to the establishment of a national health insurance (NHI) system, largely due to concerns about the challenges of the South African health system (within both the public and private sectors). It reflects growing concerns for the poor who sometimes cannot utilise health services due to high costs (not only of health services but transport to access services), employees complaining about the escalating contributions to medical schemes, and failed attempts in the past to establish such similar schemes.[14] While the official policy document outlining the details of the proposal has yet to be released, this paper seeks to provide an overview of the current health care financing system in South Africa, and to provide preliminary insights into the current debate about the NHI in South Africa. The rest of the paper is structured as follows: the next section briefly summarises some of the public-private mix issues in health financing, noting major sources of inequity. Thereafter a summary of who pays or bears the burden of health care financing in South Africa is presented. A summary of the proposed NHI follows immediately.

Public-private mix in health finance in South Africa

South Africa, like many other developing countries, has both private and public health sectors co-existing. Currently, the private health care system, when compared with the public system, accounts for the largest share of total health care financing (comprising both medical schemes and private out-of-pocket payments). In 2005, private medical schemes covered less than 16% of the population but accounted for about 45% of total health care financing. These 'medical schemes cover … high- and middle-income formal sector workers and sometimes their dependants'.[15] General tax revenue that makes up about 40% of total finance is used to cater for about 68% of the population that depend entirely on the public sector for all health services, and to heavily subsidise specialist and inpatient care for another 16% of the population. This latter group pays out-of-pocket to private sector providers for primary care services (e.g. general practitioners and retail pharmacies).[7]

The burden of the various mechanisms of funding on households varies considerably.

As shown in Fig. 1, on a per capita basis and in real terms, in 2008 about R10 000 was spent per medical scheme member while only about R1 900 was spent per individual dependent on the public sector.[7] This skewed distribution of resources is not limited to financial resources. In terms of human resources for the health sector, about 79% of doctors work in the private sector.[14] This 'maldistribution of resources between the public and private health sectors, relative to the population that each serves, reflects inefficiencies and inequities that contribute to South Africa falling far short of the Millennium Development Goals'.[14] This is not least of all due to the internationally acknowledged fact that the poor bear a greater burden of disease than the rich[16] and thus have a relatively greater need for health care. However, the well-off are the ones who are covered by medical schemes and enjoy the bulk of health care resources.

The gap between per capita spending on medical scheme members and public sector spending was lower in the late 1990s than in the late 2000s. In 1996, for instance, medical scheme spending per capita was about triple that of public spending per capita and by 2004, the gap had grown to more than seven times, and has remained at a similar level since then. It was only in the beginning of 2003 that public spending per capita began to rise, but these increases were relatively small in comparison to the pace of rises in private medical schemes' spending per capita over the decade. On the whole, combining medical schemes' spending, public spending and private out-of-pocket spending, per capita spending on health has been increasing in real terms in South Africa. While this may seem positive overall, this is largely attributable to increased medical schemes' expenditure and contributions, which, as noted earlier, is only benefiting the minority who are members of these schemes.

As demonstrated in Fig. 2, South Africa has the highest total per capita health care spending level (i.e. from public and private sources) in Africa. The implication is that there is relatively adequate per capita health care spending to provide more than the basic level of care for everyone, following from the Commission on Macroeconomics and Health's estimates of health care resource requirements.[17] However, the current distribution of such spending between the public and private health sectors relative to the populations served by each means that universal coverage has not been achieved within the resources available in South Africa overall.

It is not only the fragmentation between funding in the public and private health sectors that is of concern. Currently, there is a great degree of fragmentation within the medical schemes market. There

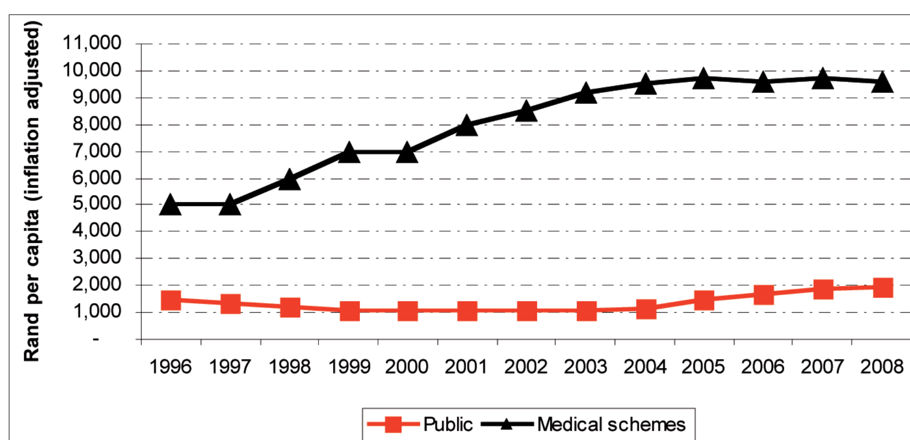

Fig. 1. Trends in real per capita spending by medical schemes and the public health sector. Source: Council for Medical Schemes Annual Reports (for medical schemes); National Treasury annual Budget Reviews (for public spending); Statistics South Africa (for CPI and population).

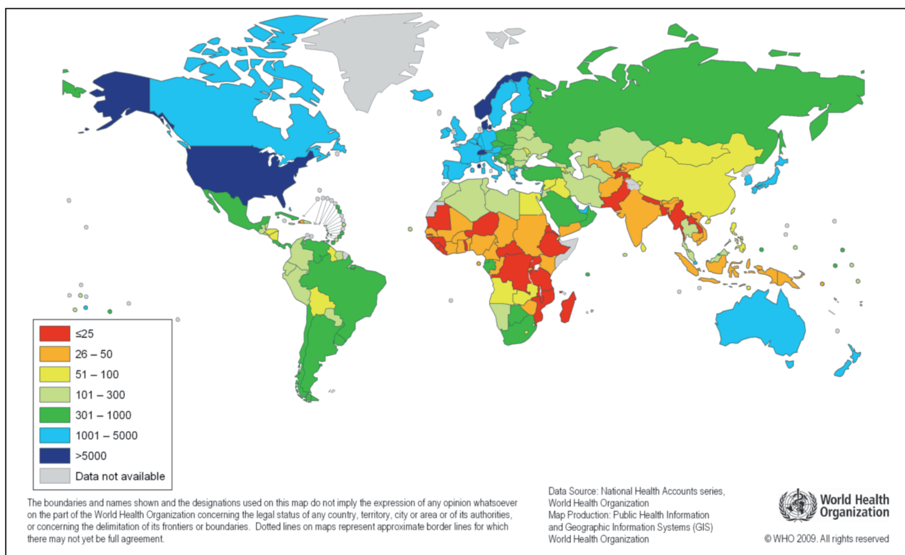

Fig. 2. Total expenditure on health per capita, 2006 (in US$). Source: World Health Organization.

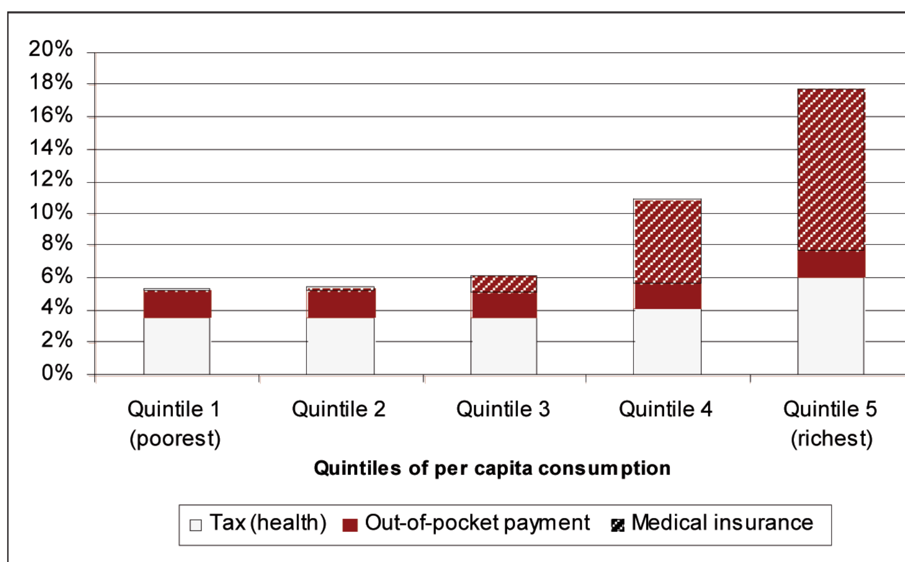

Fig. 3. Distribution of total health financing incidence in South Africa.[8]

are over 120 distinct medical schemes operating in South Africa covering different population pools, resulting in a general lack of cross-subsidisation in the overall medical schemes environment.[18] While there were moves towards developing a risk-equalisation mechanism across the current medical schemes, this has never been implemented.[18]

The NHI seeks to make the public sector 'a provider of choice'.

McIntyre *et al.*[18] argued that 'the key pooled funding mechanisms for health care are tax (and donor) funding and health insurance schemes'. In the South African context, this not only means that there is an urgent need to address the fragmentation in the existing health insurance schemes, but also that there should be a commitment from government to increase allocations from general tax revenue to the health sector without jeopardising other social service sectors. However, the health sector share of the budget has been declining from about 11.5% of the total government budget in 2000/2001 to about 10.9% in 2007/2008, which is contrary to the Abuja declaration committed to by African heads of States in 2001 that requires countries to allocate up to 15% of total government budget to the health sector.[18]

Who pays for health care in South Africa?

In South Africa, everyone contributes to health care financing in one form or another. The question however is: how do such payments vary with households' ability to pay? A recent comprehensive study by Ataguba and McIntyre[8] showed that overall, health care financing is progressive in South Africa. Basically, a financing mechanism (or system) is progressive when payments as a proportion of income increase with household income. This means that the richer segment of the population pay more as a proportion of their income than the poorer groups. If the reverse occurs, it is referred to as being regressive. When everyone irrespective of status or income spends the same proportion of income on health care, the relationship is proportional.

As shown in Fig. 3, the richest 20% of the population spend about 18% of their resources on health care compared with the poorest 20%, who spend about 5%. Looking at the individual funding components, it is clear that general taxes and private medical scheme contributions are progressive while out-of-pocket (OOP) payments are regressive. The combined progressivity of private medical schemes and general taxes more than offset the regressivity of OOP payments, leading to an overall progressive health financing system. The major driver of the progressive pattern is medical scheme contributions.

A progressive financing system has come to be generally accepted as being preferred over a regressive system on ethical grounds and in line with the principle of social solidarity. However, this is only one side of the generally accepted understanding of a fair and equitable health care system. The other side of health system equity is assessed by answering the question: who is receiving what benefits from using health services? And how are these benefits distributed? If the benefits are received according to the magnitude of health care payments, without any consideration for the genuine need for health care services, then such distribution of benefits may be described as 'unfair'. A recent study has shown that the benefits of using both public and private health sector services in South Africa are skewed in favour of the rich. The poor, with relatively greater need for health care, derive relatively less benefit from using health services in South Africa.[8]

An inequitable distribution of benefits relative to need for health care can thus exist even if the distribution of financing is progressive. This occurs because a system of financing can be progressive with little or no pooling of funds to guarantee income and risk cross-subsidisation and financial risk protection. This is unfortunately the case with the scenario presented in Fig. 3. The highly progressive private medical scheme contributions, and the regressive OOP payments, are not pooled because of the high degree of fragmentation of health care financing in South Africa.[18] This raises the issue of how to protect the poor from the potentially high costs of health care while guaranteeing them access to the

care they need. It stands at the heart of the proposed NHI system.

Moving towards universal coverage: the case of an NHI in South Africa

'There is … a great need for public engagement around what an NHI involves and about the rationale for fund pooling.'[14]

The NHI proposal by the ANC has generated considerable debate in the health policy arena, particularly among key health sector stakeholders and academics. Currently there is no formal document providing details on the specifics of the proposal, and it was only recently that a ministerial advisory committee on the NHI was constituted. The bulk of the information concerning the NHI relates to that provided at workshops and conferences by representatives of the ANC and published on the ANC website. The central theme underpinning the proposed scheme is that the South African health system needs to be restructured to ensure better performance and that it meets the needs of the people whom it is serving.

The proposed scheme is expected to have its funds pooled into a single unit or National Health Insurance Fund (NHIF). The pool will draw funds from general tax revenue, and a form of mandatory levy or health insurance contribution. General tax revenue will be the core funding mechanism. The mandatory contribution is expected to be a form of payroll tax from those employed in the formal sector and shared between employers and employees. The pooled funds from the NHIF are then expected to be used to purchase quality health services for all residents in South Africa. While tax funding is the core, this is not expected to jeopardise spending on other social services such as education, sanitation, environment, etc. as these are key social determinants of health.

It is expected that private providers will be accredited to provide services under the NHI arrangements in addition to public providers. While the exact nature of this accreditation and purchasing mechanism is not yet known, it is seen as critical to address the skewed distribution of health care resources (human and financial resources) that is in favour of the private sector.[14] Similarly, the proposed NHI does not preclude the existence of private medical schemes. However, enrolment in these schemes is optional for those who wish to obtain additional health care cover, but must be paid for over and above the mandatory NHI contribution.

The major aim of the proposed NHI is to achieve universal coverage (i.e. 'provide universal financial protection against the costs of using health services when needed'[14]) such that even those who cannot afford to pay for health care at all or at the point of utilisation, will be able to use quality health care services without the fear of financial risks and other associated losses. This is because, as some economists may argue, health care is a *merit good* (i.e. a good that an individual or society or group should have on the basis of the need for care and not necessarily because they could afford it). If health care were like any other commodity in the market, we could say that people should pay for what they demand and have what they pay for. However, good health is desirable for society as a whole and access to health care is essential to actualise better health when ill.

The legitimate concerns about the lack of preparedness of the public health sector are not in essence a valid reason for not pursuing an NHI; instead, they relate more to the pace at which an NHI can be implemented.

Part of the debates about the proposed NHI relate to concerns raised about the feasibility and the likelihood of success of this large-scale reform of the health system. The NHI seeks to make the public sector 'a provider of choice', both because it is the major provider of health care already and because there is a greater possibility of cost containment within publicly (rather than privately) provided health services if effectively managed. However, there are currently serious challenges and inadequacies in the public health sector.[13,14] Public sector health services need to be strengthened considerably and the stewardship of the government is called upon in this regard. The legitimate concerns about the lack of preparedness of the public health sector are not in essence a valid reason for not pursuing an NHI; instead, they relate more to the pace at which an NHI can be implemented. While many point exclusively to deficiencies in the public sector, it is important to acknowledge that the private sector has its own share in inefficiencies and perverse incentives associated with fee-for-service payments. In particular, medical schemes' contribution levels are becoming increasingly unaffordable and they do not provide good financial protection as members still have to make substantial co-payments,[14] which is yet another reason for pursuing a universal health system that is affordable for South Africans. Another issue related to affordability and the pace of introducing the proposed NHI is the need to recognise the impact of the recent economic recession, following the global financial meltdown, on the feasibility of having expanded fiscal resources for the NHI in the short term. The growing burden of disease in South Africa, particularly in relation to the HIV/AIDS pandemic, is also cited as a potential source of escalating the resource requirements for adequately covering the whole population. However, the issue here is that of priority setting and a coherent plan taking into account all the competing needs for resources.

Much of the debate about the proposed NHI is due to fundamental misconceptions, rather than opposition to the core principles underlying the proposals. The most important misconception relates to the NHI financing burden. Because of the current structure of the medical schemes in South Africa, where the full cost of services is covered ultimately through members' contributions, the notion of 'health insurance' is seen by many as a direct contributory system. This generates the notion that the NHI may impose untold hardship on those who are employed to pay for the health care needs of the poor and unemployed. It is important to understand that if the system is largely financed through general taxation (comprising direct and indirect taxes), all South Africans, including the poor and the unemployed, are contributing towards funding health care in the form of indirect taxes (such as VAT, fuel levies, excise taxes, etc.). Analysis of such indirect taxes in South Africa has shown a regressive pattern,[8,19] and these indirect taxes place a substantial burden on the poor already. The funding system proposed therefore is not related to the current medical schemes' model of contributions. The major envisaged source of funds to the NHIF is general tax revenue allocations to the health sector and a smaller portion coming from a progressively structured payroll tax on incomes of those in formal sector employment, financed by both employers and employees.

In conclusion

In 2005, the WHO called on countries to plan towards achieving universal coverage. The proposed NHI puts South Africa on a trajectory of achieving universal access to quality health care for all its residents. Currently the inequalities and inequities in access and utilisation of health care services place a greater burden on the poor and vulnerable. While we may argue that the proposed NHI is not a magic bullet for all the problems of the health sector in South Africa, if well designed, planned, managed and effectively implemented, it is likely to improve the overall health outcomes of South Africans as well as nudge the country towards achieving the Millennium Development Goals.

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In a nutshell

- South Africa has considered a series of proposals for the institution of variants of the NHI since the 1940s and none of these have been actualised to date.
- Lack of political support, the obstructive role of some stakeholders and the lack of general buy-in have contributed to the non-implementation.
- A very recent commitment is that which followed the ANC national policy conference in Polokwane in late 2007. However, this proposed NHI is still at a preliminary stage of development and no official document has yet been released.
- The country, though faced with rising poverty, income inequality and unemployment, is among the few countries in Africa with a relatively high per capita health care spending level.
- Such high spending levels are however benefiting largely those who contribute to medical schemes.
- Specifically, private health care financing dominates the flow of health care funds in South Africa.
- These funds are not pooled adequately and cover a minority of the wealthier population.
- Medical schemes are fragmented with little income or risk cross-subsidisation across schemes, and often members still end up making co-payments and out-of-pocket payments for services not covered by their scheme.
- We contend that even though South Africa has relatively high per capita spending on health, it is only if the funds available are pooled that access to quality health services for all South Africans can be guaranteed.