

Financing the National Health Insurance Scheme of South Africa: Opportunities and Challenges

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ABSTRACT The National Health Insurance scheme policy in South Africa is fraught with many challenges which threaten its feasibility. This paper evaluates one of the most controversial aspects pertaining to the National Health Insurance scheme which is the financing aspect of the scheme. The paper determines whether the increase of Value Added Tax (VAT) is the safest route to finance National Health Insurance (NHI) and what impact the VAT route would have on the economy and South African citizens. The paper evaluates the different methods which finances most social security schemes in South Africa. A comparative study is also made of countries which have already implemented the NHI and have determined which method of finance is most efficient to be implemented in that country from which South Africa can draw lessons from. It is however argued that finance methods from foreign jurisprudence would not be sustainable in South Africa because countries differ tremendously in terms of their history and economy. It is argued in this paper that while South Africa has successfully hosted the FIFA 2010 World Cup by building stadia and improving other spotting infrastructure, one may be under the impression that the country has enough resources to implement and finance the NHI. It is further argued that the FIFA World Cup Stadium was a once off project to build infrastructure, the NHI on the other hand must be sustainable for years to come. It is however submitted that there are many challenges that are threatening the success of financing the NHI, once these challenges are adequately addressed; NHI would be as successful as intended.

INTRODUCTION

In 2005, The World Health Assembly called on all countries to move towards universal health coverage for all especially in the developing countries where there have been huge inequality in health services delivery (Carrin and James 2004). Universal coverage is defined as “*access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care.*” Matsoso and Fryatt (2012) accentuate that in South Africa, “*a National Health Insurance (NHI) is the vehicle which is intended to bring about this change and is expected to have a lasting and recurring impact on the health of*

all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient and quality health services. Intended to be phased in over a period of 14 years, such a system will require significant overhaul of existing service delivery structures, administrative and management systems.”

In South Africa, health sector reforms have persistently increasing inequalities in access to affordable health care (Coovadia et al. 2009). While government is making frantic efforts to provide health services to the majority of the poor (Pillay and Bond 1995), the reality on the ground clearly shows that poor health services are being delivered unlike in the private organised sector where there is good delivery of health care but are provided on the basis of ability-to-pay, which has disadvantaged lower-income socio-economic groups (McIntyre 2008).

Against the backdrop of making quality health care services available and affordable to all (Olivier et al. 2004), government has developed social security systems which form part of the political choice (Giddens 2013). Social security systems, by their very nature are said to be based on the notions of solidarity and social cohesion (Stanley 2003). The most basic questions relating to National Health Financing are: who pays, how much, on what basis, and through which institutions? (Gwatkin 2004). One of the key questions that the government has to

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answer, therefore, is: how much do we want to spend on the National Health Insurance (NHI) system (Mayosi et al. 2012). Against this backdrop, there is a wide range of methods for the financing of social security arrangements including NHI. The sources of revenue can be summarised as follows: state participation; participation of other public authorities (for example, provincial and local government); special taxes, earmarked to social security; contributions from insured person; employers' contribution; income from capita and other receipts (Mack 2011). McIntyre (2007) has suggested other sources of financing through *"a high level of fragmentation in health-care provision and financing. Fragmentation refers to the existence of a large number of separate funding mechanisms (for example, many small insurance schemes) and a wide range of health-care providers paid from different funding pools. Different socioeconomic groups are often covered by different funding pools and served by different providers. Fragmentation reduces the possibilities of income and risk cross-subsidies in the overall health system."*

Objective

The objective of this paper is to determine the most efficient and more prudent method of financing NHI in South Africa. To achieve this objective, the paper evaluates different finance methods which are currently used to finance social security programmes, both internationally and nationally. The paper also evaluates the challenges and benefits of increase in Value added Tax (VAT) as a method to finance NHI.

Motivation and Significance of the Study

The study contributes significantly to the debate regarding the proper method to finance NHI. The paper makes adequate recommendations to the challenges faced by South Africa in financing NHI. The study will benefit Health Practitioners, Department of Health, Medical Students, Non-Government Organisations and countries that are yet to implement NHI.

METHODOLOGY

The research methodology used in this study is qualitative as opposed to quantitative. This research is library based and reliance on text-

books, reports, legislations, regulations and articles. Consequently, a combination of comparative and historical methods, based on jurisprudential analysis was employed. A comparative method was applied to find solutions, especially for the financing of the NHI in South Africa. The study raised the development of health care jurisprudence and social justice, and proposed solutions or amendments to the existing policies, based on practical or empirical and historical facts.

Literature Review

The success of NHI rests with the method of financing which must be adopted (Vambe 2014). It is however evident that to simply select a particular method of funding is not an easy task because of the potential implications the selected method would have on the country's economy and to its citizens (Akazili 2010). In 2005 at the fifty-eighth World Health Assembly, states' members were urged to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care (WHA 2005).

Ataguba and Akazili (2010) observe that health care financing has received considerable research and policy attention in both developed and developing countries. One of the major issues discovered was how to raise sufficient resources to finance health care needs for all citizens (Ataguba and Akazili 2010). While this is fundamental, there are other important issues such as equity and efficiency in financing. 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"* (Ataguba and Akazili 2010). Also the *"design and implementation of an adequate health financing system are essential in the pursuit of universal coverage"* (Ataguba and Akazili 2010).

According to Dalinjong and Laarhealth (2012), care financing continues to stir debates around the world. Many low and middle income countries especially, keep on exploring different ways of financing their health systems. The challenges of sustainable financing do not apply

only to South Africa but have also been experienced in other countries that follow the financing route that is currently dominant in the South African private health sector (DoH 2011). In Ghana for instance, the National Health Insurance Scheme (NHIS) which was fully implemented in 2005 is financed “by a national health insurance levy of 2.5% on certain goods and services, 2.5% monthly payroll deduction being part of the contribution to the Social Security and National Insurance Trust (SSNIT) for formal sector workers, government budgetary allocation and donor funding” (Dalinjong and Laarhealth 2012).

South Africa’s population is faced with a high burden of disease requiring careful consideration against the backdrop of the NHI (Blencher 2011). In order to implement successful Universal Coverage (UC) in health, South Africa requires diverse revenue sources (McIntyre 2012). Blecher (2011) observes that it is “very clear that for UC systems there is no clear winner between general tax funded or insurance payroll tax funded systems. Payroll taxes are important financing mechanisms in Korea, Turkey, and the Netherlands while general taxes play an important role internationally in for examples, Brazil, Australia, UK and several of these countries. Ghana has used general taxes including VAT (2.5%) as well as a small payroll tax (2.5%). It is important to note that charges are not a major source of health financing in most countries but there are very high co-payments in Korea which are of concern.”

McIntyre (2011) questioned how South Africa intends to actually implement funding universal coverage for those that are outside the formal sector as there is limited emphasis on the informal sector in the green paper and opines that “if South Africa wants to raise funding from informal sector, it is better to use indirect funding mechanisms for example, VAT, which is progressive in Ghana and has a range of exemptions compared to South Africa and it is less ideal. According to McIntyre, there are three types of healthcare financing that can be considered within the South African context, that is the mandatory prepayments, voluntary prepayments (private insurance) and out of pocket payments.”

It has been contended that in order to implement the NHI’s financing mechanism in a manner that will benefit the entire population, cer-

tain key activities need to occur simultaneously (Goldberg 2012). These include the complete and total overhaul of the healthcare system, as well as service provision and delivery. It has been further submitted that the healthcare administration and management need to be radically altered. In particular, the primary health care system needs to be re-engineered to underpin the provision of a functional and comprehensive care package (Goldberg 2012).

The question is whether premium contributions or general revenue taxes may be used for the NHI fund. There should be a positive correlation between life expectancy and expenditure (Langenbrunner 2011). South Africa is doing badly on the major health indicators (Day et al. 2011). Spending is based on “allocations from the fiscus and the use of a priority setting process. South Africa’s expenditure on health is high relative to an association of five major emerging national economies: Brazil, Russia, India, China and South Africa. (BRICS) and yet the performance of the healthcare system is poor” (Langenbrunner 2011). South Africa has fiscal capacity but the share of public priorities is very low. According to Langenbrunner (2011), “South Africa must avoid tax on the private sector labour, reasons being that there is a high level of informality (37%) in South Africa and additional taxation could adversely influence this sector.” Langenbrunner suggests that it would be prudent to increase general revenues, earmarked taxes for example, tax such as tobacco may be used since South African levels are still low compared to other countries (Langenbrunner 2011).

Fryatt (2011) suggests a variety of alternative considerations that are available to South Africa and these include “(a) a Special levy on large and profitable companies; (b) a levy on currency transactions; (c) a tax on bonds sold to nationals living abroad; (d) a financial transactions tax; (e) mobile phone voluntary solidarity contribution; (f) Sin taxes on alcohol and tobacco; (g) Excise taxes on unhealthy foods for example, salt, sugar and other ingredients; (h) the sale of franchised products for example, the Global Funds Product RED project; and (i) a Tourism tax.”

According to Fryatt (2011), “once the extra funds are raised through these mechanisms, there still remains a debate as to whether they should be ‘ring-fenced’ (or hypothecated) to

improve health. This reasoning suggests that if South Africa is already increasing funds available to health through general revenue then the arguments for hypothecation are not strong. However, South Africa has major competing, short term priorities such as ART/TB treatment and tackling maternal and child deaths, so there may be an argument for hypothecating tax for under-resourced areas for long term importance such as health promotion. This has happened in the use of tobacco tax in many parts of Asia.”

Most countries advocate for a single payer system as a progressive tool towards social cohesion, universal coverage and solidarity (Cilliers 2009). However, it is important to point out that universal coverage is difficult to achieve and it took countries decades and centuries to achieve (Schwierz 2011).

The introduction of the NHI is a good sign and it proves that the government has learned from their past mistakes in the past two decades it has been in power. The statistician has already calculated the cost of having NHI in South Africa and the question will be whether South Africa can be able to afford it (Higgins 2012). Critics believe that the government has underestimated how much such a complex scheme, covering the entire population will cost to run; there is a risk that fraud (already a massive problem in both public and private sectors) will be a serious threat (CDE 2012).

Having witnessed lot of projects which the government has completed in the last five years like FIFA 2010 World Cup Stadia (Nhlapho 2011), one is convinced that the country has enough resources to implement the NHI and there is a need for a good relationship to be developed between Government, business, the private sector and other relevant stakeholders involved (Gilson and Daire 2011).

In order for the NHI discourse to be unleashed, it should be grounded in “*a substantive conception of the good society, which should in turn facilitate the formulation of a coherent, need-focused theory of positive rights*” (Pieterse 2007). It has been contended that “*the state in a good society committed to affirmation of and respect for the inherent dignity of all human beings, must ensure some minimal level of well-being because such a threshold is necessary if citizens are to live fully hu-*

man lives and have the dignity to which their humanity entitles them.” (Marius 2007: 801-802).

This means that society must not only respect citizens’ moral agency and safeguard such civil and political liberties as are necessary for their individual and collective pursuit of the good life (Pieterse 2007), but should also ensure that all individuals in society have meaningful access to such social amenities to enable them to live in accordance with their human dignity (Benhabib 2002). It is in this context that the approach taken by the African National Congress (ANC) in its discussion documents relating to the introduction of the NHI supports it because it is a policy that is pro-poor and as such should be prioritized (Hassim 2010). Secondly rural and other underserved areas that face barriers in accessing healthcare must be given special priority (WHO 2010). It has been perceived that there are pitfalls that the NHI system will have to face, this usually relates to financial and administrative management (McIntyre 2010). However, these are challenges that can be addressed and overcome by creating systems that will oversee the whole administration of the NHI. In this respect, according to the recommendations made in the Consolidated Report of the Integrated Support Team’s (CRIST 2009), the following issues are crucial for the effective implementation of the NHI system:

- i. The need to accurately determine the exact amount of the financial backlogs in each province with the NDoH taking the lead,*
- ii. Before the implementation of the NHI, there must be accurate costing, guaranteed funding from a properly determined baseline budget,*
- iii. The Minister of Health in driving the development of the NHI, must engage the Provincial Health MEC’s and health departments and other stakeholders,*
- iv. There should be alignment between the national vision and strategy, programme strategic plans and annual national health plan, as well as between targets and interventions within the NDoH. Secondly all plans should pay more attention to implementation, and such implementation should be aligned with each other and should contain a clear framework with performance targets,*

- v. *Proposed new structures should be carefully reviewed and restructured, with a view to establishing minimum staffing levels and optimal management and administrative positions. These processes should be undertaken based on objectively agreed benchmarks, optimal application of scarce skills, the public health sector's strategic and service delivery priorities and resource availability.*
- vi. *These recommendations by the Report of the Integrated Support Team's."*

Having said all this, it is clear that the government is increasingly realising the need to look at new avenues to ensure greater inclusivity of the right to have access to health care (Gruskin et al. 2007). It is hoped that the possibilities presented in this paper are also explored as new ways in which to widen the social security net. Interestingly, it has been observed that *"the NHI has a potential of identifying human rights based practices and methods for developmental efforts in fighting the scourge of poverty and other ills aggravating the realisation of two highly interrelated human rights, namely the right to dignity and the right to health care"* (Mabidi 2013).

Financing of the NHI

The method of financing of NHI should be from all diverse but available revenues (Mills et al. 2012). *"The generally accepted core of universal coverage is that the health system should be financed in accordance with the ability to pay, and benefits received in accordance with the need for health care."* Felner (2009) points out that all methods grapple with the problem of balancing two extreme approaches, namely, the principles of solidarity versus those of self-sufficiency. In this context, the South African government has considered the following strategies of funding the NHI, such as payroll tax (payable by the employers), an increase in the VAT rate and a surcharge on individuals taxable income (Stevens 2012).

In the 2013 budget speech, the Minister of Finance suggested that VAT may indeed be increased in order to finance NHI. *"The initial phase of NHI development will not place new revenue demands on the fiscus. In the long term, however, it is anticipated that a tax in-*

crease will be needed. The National Treasury is working with the Department of Health to examine the funding arrangements and system reforms required for NHI." It would seem that the increase of VAT would go a long way in helping to meet the government's goal of funding an effective NHI within 14 years (Bauer 2011). This suggestion would not seem to be unreasonable considering that NHI will benefit all South Africans and legal residents so it is only fair that everyone should pay for its funding (Bauer 2011). Congress of South African Trade Unions (COSATU) is one of the organizations not supportive of the suggestion that VAT be used to fund NHI. While COSATU concedes to the NHI's aims at accessibility and affordability of health care, it however argues that reliance on VAT would defeat the purpose by placing pressure on those with the least money (Seekings and Matisonn 2012). COSATU argues that those who are supposed to benefit will suffer the most (Bauer 2011). Experts however disagree with COSATU's arguments which seem to suggest that the increase of VAT would put those who are most economically vulnerable at risk. It has been pointed out that the revenue collected through VAT is driven based on consumption by the people (Bird and Gendron 2006) and the NHI also has similar characteristics (Storom 2013), people will consume health care services in order to be provided by the scheme and through that, a lot of socio-economic goods and services will be provided and paid for. The implication of this is that in the process of implementation, the costs of financing the NHI are being offset to a certain extent within the consumptive chain (Coovadia et al. 2009). It has been observed that *"it is unlikely that anybody who buys a flat-screen TV would have a problem with a portion of the VAT included on the item being increased to fund NHI so in essence, the poor would not be affected"* (Bauer 2011).

When considering that the average VAT rate in the European Union (EU) is higher than 21% and the average global VAT rate is between 18% and 20%, the 14% VAT rate in South Africa appears to be low in comparison (Ebrill 2001). Watson (2013) points out that *"the South Africa's VAT rate has remained unchanged at 14% since its increase from 10% in 1993. The Netherlands recently announced an increase in its standard VAT rate from 19% to 21% in an effort to bring the country's current budget deficit to below*

3% of Gross Domestic Product (GDP).” The increase of VAT rate could be justified on efficiency grounds because it has raised substantial revenue for the government to finance its socio-economic services (Heady 2002).

In the Budget speech of 2011, the government said that it *“has also sought to invest in health services by establishing a health infrastructure grant, new facilities were built and existing ones upgraded...in addition, a family health approach to primary health care has been launched, at a cost of R1.2bn, over the next three years...teams comprising nurses, doctors and community health workers would look after families in revitalised public health facilities, with an emphasis on prevention rather than cure.”* Furthermore, *“the government has set aside R2.7 billion to improve the quality of health care services in hospitals, a total of R117m had been allocated to set up an Office of Standards Compliance, an independent authority that would include an inspectorate and an ombudsman. The review stated that spending on the health sector was expected to grow from the current R102.5bn to R113bn in 2011\12, and R127bn in 2013/14 - an average annual growth rate of 7.5%.”*

More importantly, *“the budget allocated an additional R1.4bn to improve maternal and child health services through a range of interventions that included training 400 nurses and midwives, improving school health services, and better supervision of obstetric and paediatric services in district hospitals.”* According to Gordhan, the Minister of Finance these and other improvements to the public health system will require higher revenues to ensure adequate financing over the long term (Mabidi 2013).

Furthermore, the Chairperson of the NHI Ministerial Advisory Task Team (Shisana 2010) pointed out that, *“the project’s success and incremental roll-out from 2012, when it would cost R128 billion (nearly tripling to R375.5 billion by 2025), would be built on the ‘redirection’ of resources via stringent budget measures and identification of cost drivers. The biggest systemic cost drivers at present are ARVs (where much greater purchasing efficiencies could be achieved), the National Health Laboratory Service (NHLS) and equipment. ‘Unless we address these three (before 2012), it will be very difficult to start the process,’ she admitted in response to a question on how the current*

R11 billion shortfall on the 2012 NHI budget would be addressed.”

In March 2012, *“South Africa announced 10 districts across the country that will pilot the universal health care under NHI. However, the 10 NHI pilot sites have been given a paltry R11-million each”* (Health 2012). NHI is about comprehensive reform of the health care system, as a result, R11 million rand allocated to each the district is not sufficient to run a comprehensive healthcare system that would adequately improve the health care services in South Africa.

Shisana (2010) said *“probes into the health care staffing crisis also showed a disproportionate increase in management and administrative structures at national and provincial level. Her team was working with the Colleges of Medicine and the Committee of University Deans to establish how many doctors and specialists were needed (let alone how to address the current 35% shortfall on existing public sector posts).”*

Against this backdrop, in order to facilitate the commencement of the scheme, Shisana (2010) said *“nursing colleges would shortly be opened and a better balance between academic and bedside training strived for. Supportive legislation needed passing, minimum standards for compliance and subsequent gradual NHI hospital accreditation was being completed while management standards were being drastically improved with a hospital-by hospital audit of managers and we must make sure we have sufficient health professionals capable of doing the work they are supposed to-and ensure a change of attitude and clinical standards across the board in management.”*

Pursuant to and in order to reinforce above mentioned promises, enshrined in the Constitution is that every person has the right to achieve optimal health (Singh et al. 2005). It is the responsibility of the government to provide the conditions to achieve this constitutional obligation (Cabrera and Ayala 2013). Some commentators might contend that this right is not achievable (Arras and Fenton 2009), whilst others argue that this right is presently not equally enjoyed by all, that it is limited to *“the affluent members of the society”* (Hendricks and Botha 2008).

With this in mind, it is clear that since the advent of democracy, South African government has been looking at ways to undo some of the

apartheid systems legacies (Finchilescu and Dawes 1998). This principally speaks to the establishment of the NHI as a strategy of achieving the constitutional right of access to health for all.

Will the National Health Insurance be Affordable for All?

In South Africa, health care is fragmented and highly characterised by high cost and inaccessible to the majority of the poor people and foreigners (Winkel 2010). According to Goldberg (2012), *“the current fragmented healthcare system, characterised by its high-cost, hospital-centric and curative approach is regarded as unsustainable.”* However, from the preliminary costing estimates done by the stakeholders, the outcome showed that the NHI is affordable (Van den Heever and Suzman 2011), sustainable and that it will be of immense benefit for the health sector and the people that will benefit from it (Annandale 2010). Implementation of the NHI will *“require that payments for healthcare are made in advance of an illness, and that these are pooled and used to fund health services for the population”* (Amollo 2012). Even though there are likelihood of challenges and risks that will exist during the course of implementation (Komape 2014), *“plans to mitigate these are being put in place; in particular, to continue the process of consultation, improving on communications (including the timetable for changes to happen), strengthening oversight of the reform process in existing and future pilot districts and keeping a focus on equity to ensure that introducing the NHI will lead to a fairer healthcare system”* (Matsoso and Fryatt 2012).

The majority of the funding for the NHI will come from government-owned entity that is publicly administered by the South African Revenue Service particularly through tax revenue and the mandatory contribution (Tshivhase 2013). The government has given all assurances on the sustainability of funding for the NHI and stressed that the implementation of the NHI will enhance the public health sector’s capacity to provide quality health care to poor and disadvantaged people (Tshoose 2013). Through the NHI, the health care services will be improved, at the same time jobs will be created in the health sector and this will in turn increase the (GDP) of

the country as a whole (McIntyre 2010). The issue of affordability had been strengthened through the address given by the government on the need to continue to ensure continuous growth in the economy so as to continue to afford to fund the NHI and it was asserted that (Fraser 2011) *“if we succeed in driving growth towards 5% a year and government revenue doubles in the next 20 years, major infrastructure projects and new policy initiatives such as NHI will be affordable with limited adjustments to tax policy. But if growth continues along the present trajectory, substantial spending commitments would require significant adjustments in revenue and (spending) reductions”* (Kahn 2013).

CONCLUSION

Even though the public healthcare service is dysfunctional and the majority of the poor people have been failed by the Government in this respect, the NHI is a good policy which would allow the poor to have access to affordable and sustainable quality health care services.

The rationale for introducing NHI is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. The Department of Health has emphasized that the NHI will improve access to quality healthcare services and provides financial risk protection against health-related catastrophic expenditures for the whole population. The Department of Health has also indicated that the NHI is tied to a mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual’s ability-to-pay and benefits from health services would be in line with an individual’s need for care. The key aspect of this is that access to health services must be free at the point of use and that people will benefit according to their health profile.

RECOMMENDATIONS

This paper seeks to recommend that the Government must involve all stakeholders especially the health sector in the NHI and avoid centralising it with the ruling party, the ANC and the alliance partners. The Government must hold an indaba which involves people from academia,

civil society organisations, medical practitioners and all health professionals to make recommendations on how best the NHI can be implemented and which model is viable. The current state of the infrastructure that South Africa have cannot be able to accommodate the NHI proposals and a way forward of establishing a Public Private Partnership might be the best option going forward.

It is also recommended that the NHI proposals should be legislated and clearly state who will be the administrator of the NHI. This will remove a lot of uncertainties amongst different stakeholders. The President of South Africa, after consultation with the cabinet ministers must appoint an independent task team not aligned to political parties to develop comprehensive policy on NHI and to work towards a bill which will guide the promulgation of the new Act or the amendments of the National Health Act.

Further, the Government should also look at the options of giving incentives to students to encourage them to pursue or upgrade their careers in the health fraternity either as doctors, nurses, paramedics, pharmacists and social workers and psychologists to develop capacity which will strengthen the NHI. Further, the NHI must promote the principle of corporate governance, accountability and transparency in the health sector.

LIMITATIONS OF THE STUDY

This paper examines the most efficient and prudent ways to finance the NHI in order to make it accessible and affordable for all, hence the scope of the study is limited to financing of NHI in order for all to benefit especially the poorest of the poor in South Africa. As such, the mechanisms proposed in this paper will, it is hoped, serve as a yardstick for stimulating further debate and generating new ideas on how to improve the health care delivery services for all in South Africa.

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