

## **Health financing and the National Health Insurance in South Africa: An overview**

Article by: Consultancy Africa Intelligence CAI <sup>1</sup>Written by Deanne Goldberg<sup>(1)</sup>

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No matter their level of income, all people desire protection from the personal and financial risks associated with ill health.<sup>(2)</sup> Nevertheless, each year millions of Africans face financial crisis as a result of insufficient means to access adequate health services.<sup>(3)</sup> As a result of the rising numbers of people with little or no access to basic health services, countries across Africa have recently placed healthcare high on their development agendas. In South Africa, this critical human right to health and protection from risks are enshrined in the Constitution.<sup>(4)</sup> In order to combat socio-economic discrepancies and inequalities in access to health services, the South African Department of Health has proposed the National Health Insurance (NHI) as a “financing system that will make sure that all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund.”<sup>(5)</sup>

This discussion paper presents a brief introduction to the principles of universal coverage and the nature and content of the proposed NHI plan. It will then move on to discuss the potential benefits and challenges of the NHI based on differing opinions held by major stakeholders.

### **Health financing and universal coverage in an African context**

With high levels of burden of disease (BOD) globally and on the African continent particularly, health financing has become an increasingly important area of concern for policy makers and healthcare providers. While Africa is home to only 12% of the world’s population, its disease burden is vastly disproportionate,<sup>(6)</sup> with Sub-Saharan Africa alone accounting for 22% of the global BOD.<sup>(7)</sup> This region also accounts for only 1% of the world’s health expenditure and 2% of the global health workforce, making it concurrently one of the worst-affected and most ill-equipped to combat its poor health status.<sup>(8)</sup> For example, 2005 estimates suggest that in Kenya and Senegal over 100,000 households, and in South Africa over 290 000 households, were forced below the poverty line due to their healthcare expenditure.<sup>(9)</sup>

The low levels of domestic investment in healthcare in some African countries have significantly impeded their progress towards the Millennium Development Goals compared to their global counterparts.<sup>(10)</sup> Large gaps exist between the resources needed and those available to respond to the health challenges. Health system bottlenecks, coupled with poor resource mobilisation, mean that governments’ capacity to respond to health crises becomes increasingly complicated.<sup>(11)</sup>

The South African government, among others, has therefore called for a move to a national health insurance policy. This type of system is premised on the idea of universal coverage promoted by the World Health Organisation (WHO). This approach proposes a healthcare delivery system whereby financial expenditure is managed so as to share risk amongst all individuals in a population and prevent impoverishment as a result of seeking care. Under a system of universal coverage, infrastructure and human resources for healthcare should be sufficient to support the provision of equitable, quality health services. Three major health-financing functions are regarded as central to achieving universal coverage: revenue collection, pooling of resources and purchasing and provision of services.<sup>(12)</sup> Countries developing such plans must consider the unique macroeconomic, political and socio-cultural profile of the nation and should, where possible, capitalise on pre-existing relationships. Collaboration between private and public service providers, guided by strong government stewardship, is essential. Sharing of successful development experiences across the healthcare spectrum in order to enhance service delivery across the board is encouraged.<sup>(13)</sup>

### **Healthcare in South Africa: Introducing a National Health Insurance<sup>(14)</sup>**

The South African healthcare system includes private and public service providers.<sup>(15)</sup> The public healthcare system is funded primarily by the fiscus and, as far as possible, provides free care at the point of service to the majority of South Africans. Due to high patient volumes and poor funding, the public healthcare system is often associated with being poor on safety, patient management, stock availability and infection control. This has resulted in poor staff morale, under-maintained facilities and an overall compromised quality of service provision in public health facilities.<sup>(16)</sup> The private sector services a smaller portion of the population who, by virtue of their employment status, elect to purchase benefit options through a medical scheme or pay out-of-pocket.

An estimated 8.3% of South Africa's gross domestic product (GDP) is spent on healthcare. Of this, 4.1% is spent on the 16.2% of the population using private sector healthcare services. The remaining 4.2% serves the 83.8% of the population using public healthcare services. This discrepancy in the distribution of funding has created a tiered and polarised healthcare system. Historically inequitable service provision among population groups, declining infrastructure and the increasing cost of health have meant that the gap between the private and public health sectors has grown increasingly wide. It is now imperative that the problems facing many South Africans as a result of poor and biased health financing be addressed.

The development of a national health system has been a focal point of discussions and proposals surrounding health sector reform, and is guided by the tenets of the African National Congress's (ANC) 1994 National Health Plan.<sup>(17)</sup> Following consultation with the Ministry of Health's National Health Insurance Advisory Committee, the NHI Green Paper was released in August 2011 for public comment.<sup>(18)</sup> The introduction of the NHI endeavours to eliminate the flaws of the current system by improving access and ensuring financial risk protection against the high expenditure associated with healthcare. Implementation would ensure all South Africans equitable and sustainable access to quality healthcare based on the severity of illness rather than financial capacity.

The fundamental offering of the proposed NHI is that all South Africans, irrespective of employment status, will have access to a pre-defined comprehensive health service package. This package will make care available at all levels with guaranteed continuity of benefits. Services provided will be within the bounds of that considered achievable for implementation, commensurate with national resources. Co-payments at the point of service may only be necessary when services are beyond those defined under the benefits package. Ultimately, the NHI seeks to create fairness in the sharing of healthcare finance and other resources, including the distribution of skilled health professionals. By pooling funds and risks between the rich and poor, healthy and unhealthy, young and old, the NHI may achieve equity and social solidarity.

International evidence suggests that benefit packages should be determined by an assessment of the most pressing needs of the particular recipient group and prioritise enhanced accessibility of healthcare services. The package norms to be provided in geographic districts will assist in determining appropriate and measurable targets. These will be implemented according to certified service provision standards. Such norms will enable managers at all action levels to compare and contrast performance and challenges between individual and groups of similar facilities.

The Green Paper proposes seven guiding principles for the development, implementation and sustainability of a national health insurance policy, which aim to consolidate and coordinate the value and effectiveness of implementation. These are: right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.

The NHI aims to reduce direct costs for healthcare felt by families and households, and thereby prevent cases in which households are forced to face impoverishing and potentially catastrophic consequences as a result of healthcare costs. The NHI is configured so that those individuals earning above a specified income level will be required by law to make a monthly NHI payment,<sup>(19)</sup> while those with incomes below this threshold will not be required make any direct payments to the fund. Further, employers would have a role to play in coordinating and supporting their employees' contributions. Payment would be aligned with an individual's ability to pay, and benefits aligned with the individual's need for care. However, the precise parameters and conditions for payment are not specified in the Green Paper as it stands.

The Green Paper contends that to create the systems necessary to support the NHI successfully, an improvement in healthcare quality and pricing regulation, as well as the rigour of planning, service provision, information management and administrative systems is paramount. In order to coordinate national healthcare access information, two important mechanisms to support implementation have been identified. For a citizen to receive treatment under the NHI, they will need to be registered with the Department of Home Affairs. The creation of a coordinated and integrated health information system will support enhanced efficacy, confidentiality, portability of information, decision making and systems planning. This will enable improved availability of information for healthcare providers regarding services dispensed across the population, no matter the site or provider. Information gathered in this way will provide

useful and representative indicators for tracking the dispensation of the health funds and monitoring BOD at national, provincial and district levels.

In order to implement the NHI's financing mechanism in a manner that will benefit the entire population certain key activities need to occur simultaneously. These include the complete and total overhaul of the healthcare system, as well as service provision and delivery. 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.<sup>(20)</sup> Work is already underway in the National and Provincial Departments of Health to support the delivery of primary health care services. Importantly, service delivery will be population-oriented and draw on community capacity and infrastructure, including local health workers and home-based healthcare. This reinforces the move away from hospital-centric model of care that has dominated until recently and will also assist the under-performing institutions in the public sector which have suffered a decline in service quality and capacity due to inadequate funding, poor management and decaying infrastructure. The improvement in resourcing will be a primary focus during the first seven years of implementation, as the re-engineering of the primary health care system is regarded as an urgent intervention.

The district health system (DHS), supported by district clinical specialist and support teams will be the vehicle by which all primary health care is delivered. The district team will aim to integrate the activities of general practitioners and hospital-based specialists and to provide support to those working in primary care. The implementation of stringent treatment guidelines and protocols, coupled with enhanced human resources will serve to enhance the quality of service provision.

The Ministry of Health has begun to take action to facilitate the implementation of the NHI and revitalise the system's capacity for quality healthcare service provision. Included in these efforts are the improvements of the facilities of six major public hospitals supported by private companies, and the drafting of legislation to ensure that all those in supervisory or management roles are appropriately qualified and experienced. A regulative body called the Office of Health Standards Compliance (OHSC) will be responsible for the inspection and accreditation of hospitals, facilities and practitioners to ensure that they are in compliance with the required standards. This regulatory body will be legislated through three main divisions: inspection, norms and standards, and the office of the ombudsperson. All healthcare providers that wish to be considered for rendering health services will have to meet set standards of quality to be accredited by the OHSC. Regular assessments will be conducted to ensure that set standards are maintained. The results will be used to guide recommendations for quality improvement in public healthcare facilities with associated training.

The Green Paper lays out a timeline in three phases over a projected 14 years, beginning in 2011 with the publication of the White Paper and reaching full implementation in 2025. This is based on estimates from implementation processes from other countries, which have suggested that capacitation of facilities and healthcare providers to accommodate the utilisation increases associated with the NHI will take time.

Beginning April 2012, the NHI will be piloted in 10 priority districts, selected on the basis of an audit conducted by the National Department of Health. The audit will take into account the state of healthcare facilities, as well as a number of key indicators. Selection will be informed by district demographic and health profiles, service delivery and performance, income levels, quality standards compliance and socio-cultural profiles. This pilot will inform the structure of governance and district management systems, as well as serve as a mechanism for testing the rollout of the proposed NHI service package. The pilot will be extended at a later point to 20 districts. Ultimately this capacitation process will serve to strengthen the proposed District Health Authority - a contracting unit charged with managing contracts through the relevant accredited provider.

### **Is it affordable?**

The current fragmented healthcare system, characterised by its high-cost, hospital-centric and curative approach, is regarded as unsustainable. In contrast, preliminary costing estimates suggest that the NHI is affordable and sustainable. The funds will be drawn from a combination of sources (e.g. individuals, employers and the fiscus). To implement this 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. The precise combination of sources is the subject of continuing technical work and will be clarified in parallel with public consultation. The NHI Fund will be established as a government-owned entity that is publicly administered with the South African Revenue Service being responsible for revenue collection.

To implement the NHI, an increase in health expenditure - through tax revenue and the mandatory contribution - that exceeds projected GDP increases is required. However, the level of spending necessary to achieve universal coverage in this way is less than that being spent currently by government and through medical schemes – an estimated R227-billion is currently being spent on healthcare services in South Africa (inclusive of private and public health-spend).

Finance Minister Pravin Gordhan, addressing the issue of the feasible introduction of the NHI, has stated that he sees “no immediate risk of a fiscally unsustainable process emerging.”<sup>(21)</sup> He stressed that the envisioned long-term implementation program would focus on enhancing the public health sector’s capacity to provide quality health care. He further emphasised the government’s commitment to ensure sustainability throughout this process and to ensure the proper management of inter-generational debt.<sup>(22)</sup>

Professor Di McIntyre has supported this and suggested that the required spend to implement the NHI would approximately match the amount currently spent by government on healthcare.<sup>(23)</sup> An investigation by KPMG auditors on whether the cost-benefit of the investment in healthcare proposed in the NHI outweighs the tax payments needed to fund it over the proposed 14 year implementation period, notes that there remains potential for the NHI to improve the health of the population and in turn increase the GDP of the country as a whole.<sup>(24)</sup> However, opposing these views, director of Econex, Nicola Theron, has stated that at an estimated minimum cost of R196 million the implementation of the NHI may well be unaffordable.<sup>(25)</sup>

## **Opportunities and potential benefits of NHI**

Considering debates regarding the affordability of implementation, KPMG Head of Health for Africa and South Africa, Sven Byl, reminds that, “When analysing the potential cost of NHI, one can fall into the trap of considering healthcare expenditure only as a cost to the economy. Spending on healthcare is a long-term investment in the human capital of South Africa.”<sup>(26)</sup> This highlights the potential impact of sustainable and equitable access to healthcare on the productivity of the nation.

The benefits package available to all citizens under the NHI will contain health promotion, disease prevention, curative and rehabilitative components.<sup>(27)</sup> This represents an enhancement of a previous model primarily focused on curative interventions rather than holistic healthcare.

Dr.Motsoaledi reminds that although the private sector and medical schemes are also affected by the introduction of the NHI, the NHI should not be conceptualised as a war between private and public sector health coverage.<sup>(28)</sup> Private hospital and specialist costs have increased by approximately 120% each over the past decade, which has created a situation whereby service access is insufficient as a result of schemes’ and benefit packages’ designs.<sup>(29)</sup> Costs of private health care are escalating faster than the costs of living, and the NHI aims to repair this gap in access by providing equitable access to necessary services and thereby reduce reliance on private healthcare funding.

In his recent state of the nation address, President Zuma noted that the government has prioritised NHI implementation through “critical social infrastructure projects.”<sup>(30)</sup> These include dedicating national efforts to the refurbishment of healthcare facilities. Re-engineering of the primary healthcare system will place considerable focus on health promotion and preventative care aspects. This re-orientation of the healthcare system has the potential to significantly improve South Africa’s national health status.

### **“Strong on the what, but less so on the how”: Critiques and potential challenges**

KPMG’s Director of Global Health, Dr. Mark Britnell, has described the Green Paper as: “strong on the what, but less so on the how.”<sup>(31)</sup> Two of the major critiques of the Green Paper noted by commenting parties, political and academic, are that the concept of the basic “benefits package” is not expanded on to explain what benefits this would include. It is further contended that funding requirement estimates are inadequately explained and do not accommodate for price inflation.

The Congress of South African Trade Unions (COSATU) has welcomed the NHI but also openly expresses its concern regarding the inclusion of medical schemes in a “multi-payer” system, suggesting that this will sustain inequitable service delivery and “undermine” the implementation of the NHI.<sup>(32)</sup>

The Democratic Alliance (DA), the ANC’s primary opposition, has released a position paper which suggests that the Green Paper is founded on the faulty notion that the

government's failures in health service delivery are as a result of private sector success.<sup>(33)</sup> It further contends that, "the promotion of such an argument suggests that the Health Ministry not only misunderstands what is wrong with healthcare, but remains blind to its own responsibility in creating the problems the health system now faces."<sup>(34)</sup> The Helen Suzman Foundation (HSF) has echoed this sentiment in their position paper, highlighting a lack of evidence-based support for claims that private and public sector inequalities are the primary cause for poor health outcomes and the state of South African healthcare.<sup>(35)</sup> The DA also notes an approximately 30% difference in levels of patient satisfaction between public and private health consumers, with the latter experiencing considerably higher levels of satisfaction. They also recommend that by incentivising healthcare practitioners to enhance performance, levels of patient satisfaction in the public sector may increase.<sup>(36)</sup> The DA offers ten reasons why the NHI is not the solution to the nation's current health crisis, including statements such as "We lack the human resources to implement NHI," "NHI does not adequately attend to accountability and management structures" and "NHI eradicates freedom of choice for healthcare consumers."

Professor Alex van den Heever has suggested that the establishment of a centralised fund may carry considerable risk and destabilise an already unsteady, under-performing public health sector. He suggests that decentralisation of funding is critical to efficient functioning at a provincial level, and that political governance models may be insufficient to accommodate the administrative and procurement responsibilities central to an effectively implemented NHI.<sup>(37)</sup>

Professor Heather McLeod has called attention to an interesting clarification that must be made between universal coverage for healthcare, and universal coverage for health insurance. She points out that while less than one in five South Africans have insurance coverage, all have access to healthcare through various channels of service delivery.<sup>(38)</sup>

## **Way forward**

Given the current multiplicity of opinions regarding the validity of the proposed NHI implementation plan, it is certainly valuable to consider the state of commentary and opinion. The HSF position paper notes that public consultation, key stakeholder engagements and dialogue with civil society are imperative to providing clear stewardship and preventing the spread of misinformation.<sup>(39)</sup>

This consultation process will guide the development of a consolidated White Paper, which will be implemented in legislation after approval by Parliament, and ultimately approved as a Bill by the President of the Republic.<sup>(40)</sup> The timeline laid out in the Green Paper recommended that this process be complete at the close of 2011, however, to date a White Paper has not been released.<sup>(41)</sup> Acknowledging this however, to create a national insurance plan that is the cumulative result of the consultation recommended here may require a longer period for consolidation.

## Conclusion

This paper presents a brief overview of the proposed introduction of a National Health Insurance in the context of South Africa's current health profile. The NHI aims to provide equitable, quality healthcare to all South Africans, regardless of employment or socio-economic status. By improving the quality of healthcare and ease of access, the health of the nation will be improved and BOD reduced. The voices of proponents and opponents have resonated across sectors, and consolidation of the results of these stakeholder consultations will inform the ultimate form of the National Health Insurance Plan. All agree, however, that equal access to health services for all South African is and must remain the primary goal.

## NOTES:

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