Health financing reforms to achieve Universal Health Coverage: Case Study of the SA National Health Insurance

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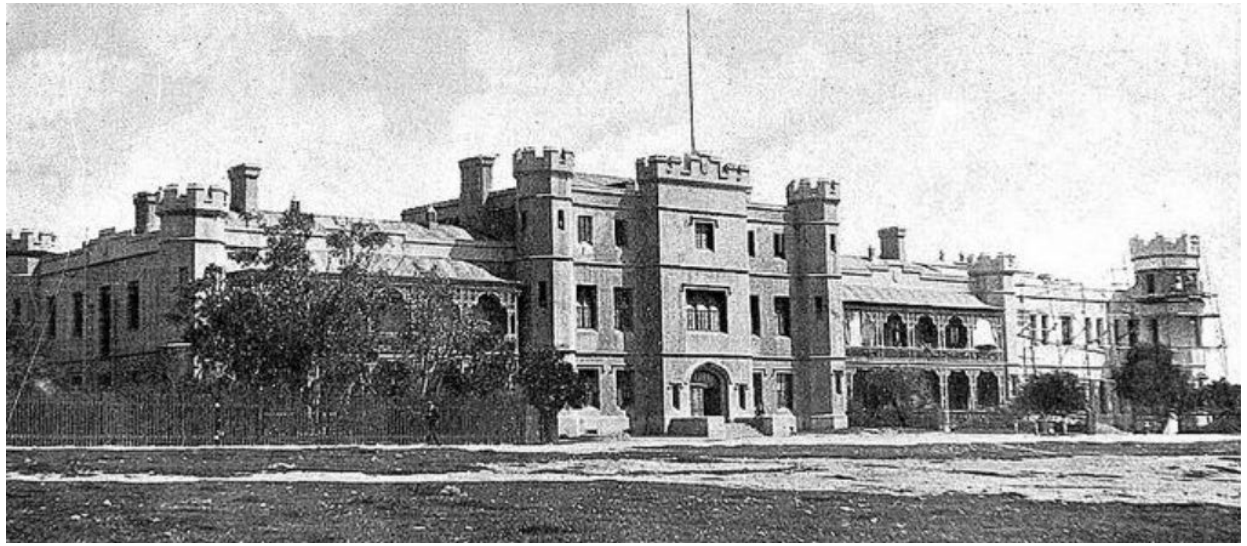
HEALTH ECONOMICS AND HIV AND AIDS RESEARCH DIVISION

Overview

- History of SA health system
  - Colonial period
  - Apartheid period
  - Democratic era
- National Health Insurance revenue raising & pooling
- Marketisation of the health system
- State in financial crisis
- Financial coverage in a state in crisis
- Conclusion
- Exercises

History of SA health system

- First western health care facility built in the 1600s at Cape of Good Hope.
- First matron and nurse trained in 1700 by the Dutch East India Company
- First hospital built in South Africa in 1818 in Cape Town.



History of SA health system

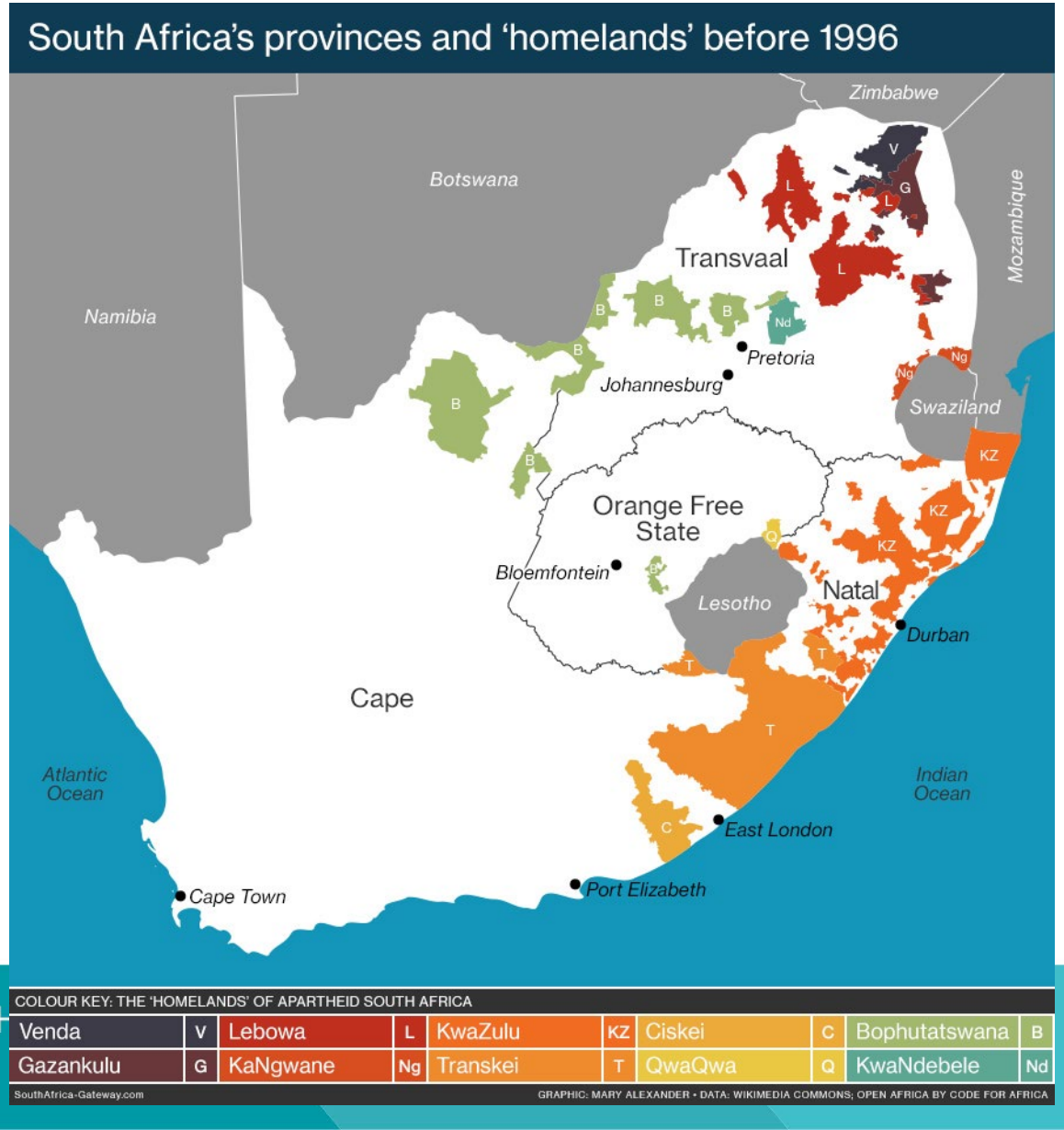
- There was no coherent organizational structure of health care by the time of the South African union (1910).
- Health care was focused mainly in the urban areas (Coovadia, 2009).
- Health care was already racially segregated by the time of the Union.
- Political unification did not lead to a unified health system.

History of SA health system: Gluckman commission

- Following the Second World War, Henry Gluckman setup a commission in a bid to outline a National Health System in South Africa.
- 400 health centres across urban and rural sectors.
- Partially driven by the UK setting up its own health system.
- The Smuts Union government at the time rejected many of the Gluckman Commission's recommendations as expensive and utopian

History of SA health system: Homeland health services

- During the 1950s established a separate health service for the ‘homelands’.
- The health service sought to exclude black people from urban health care and welfare services and forcing urban-based elderly and ill black people to seek services in the homelands.
- The underdevelopment of the homeland health care system still has a detrimental impact on South Africa’s health system today (Stuckler et al., 2011).



History of SA health system: rapid privatization in 1980s

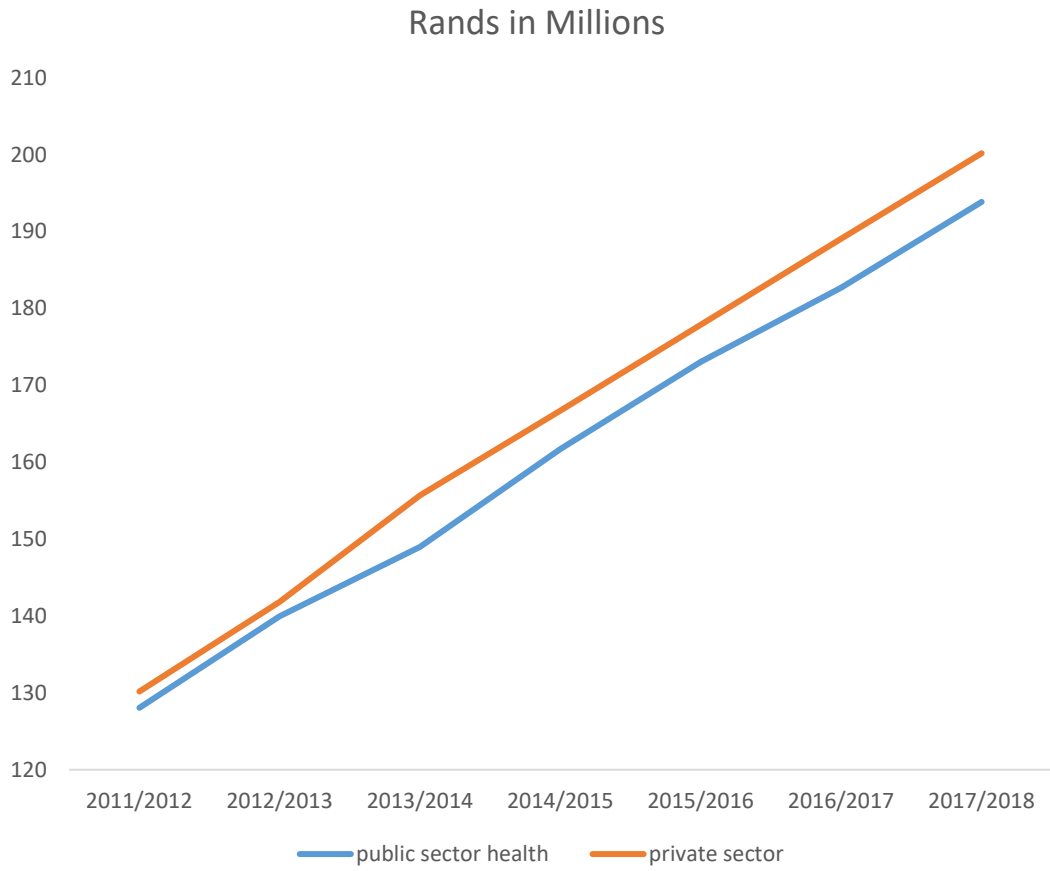
- Health care privatisation rose rapidly in the 1980s following a long period of increasing state involvement in the economy (Naylor, 1988).
- Three privatisation initiatives undertaken:
  - Government subsidised private health insurance
  - User fees for public health care
  - Deregulation of medical insurance industry
- Surge in private spending in health care. Approximately 40% of doctors were working in the private sector. Early 1990s this number increased to 62% (McIntyre, 2010). Between 1988 and 1993, the number of beds in the private sector increased by 88% (McIntyre et al., 1995).

History of SA health system: Democratic era

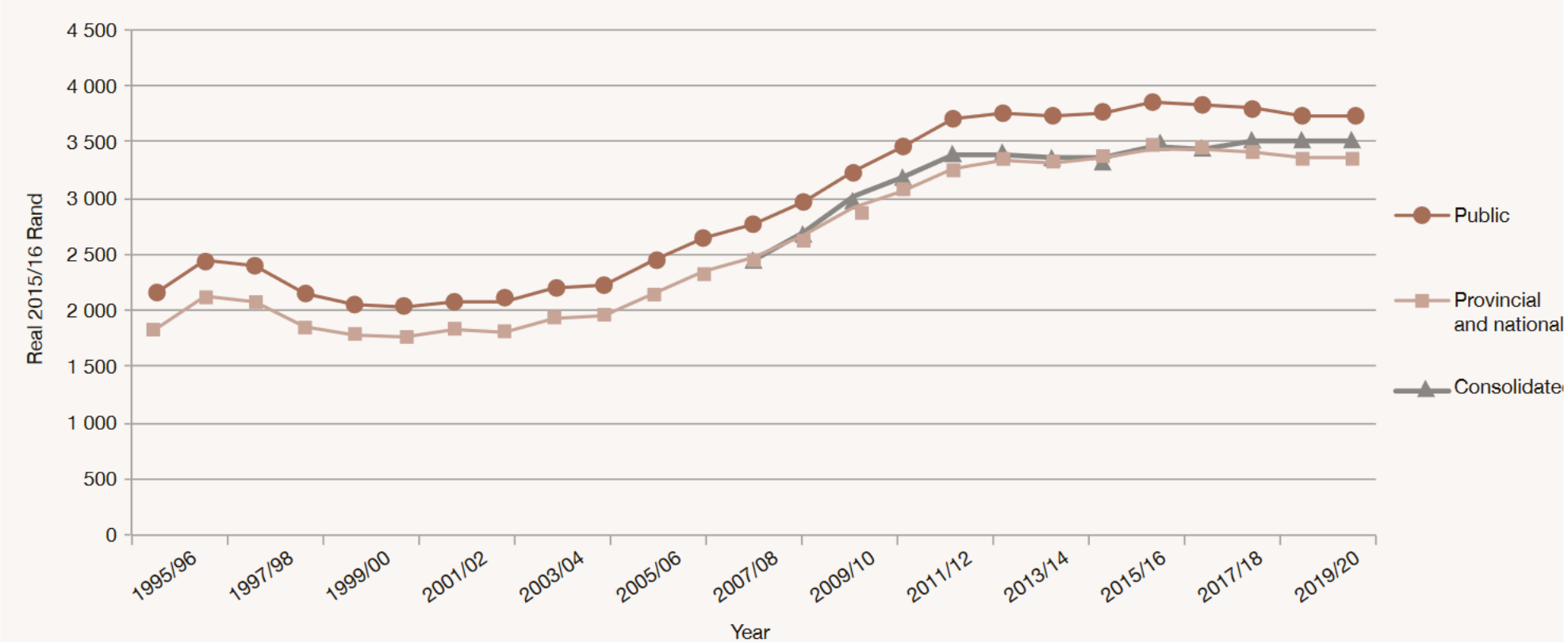
- The public health system was bureaucratically and geographically fractured and grossly underfunded.
- The most critical health care priority of the post-apartheid government was to undo the racial discrimination and underdevelopment inflicted upon the South African public health system by centuries of colonial and apartheid rule.
- The ANC-led government disbanded the homelands and unified the 14 homeland health departments into one national and nine provincial health departments to create an integrated, comprehensive national health service.
- Consequently, 1 345 new clinics were built and 263 pre-existing clinics were upgraded (Coovadia et al., 2009).
- From 1994, children younger than six years old and pregnant mothers could receive free health care, and in 1996 user fees were abolished for all PHC services (Coovadia et al., 2009).

The current situation

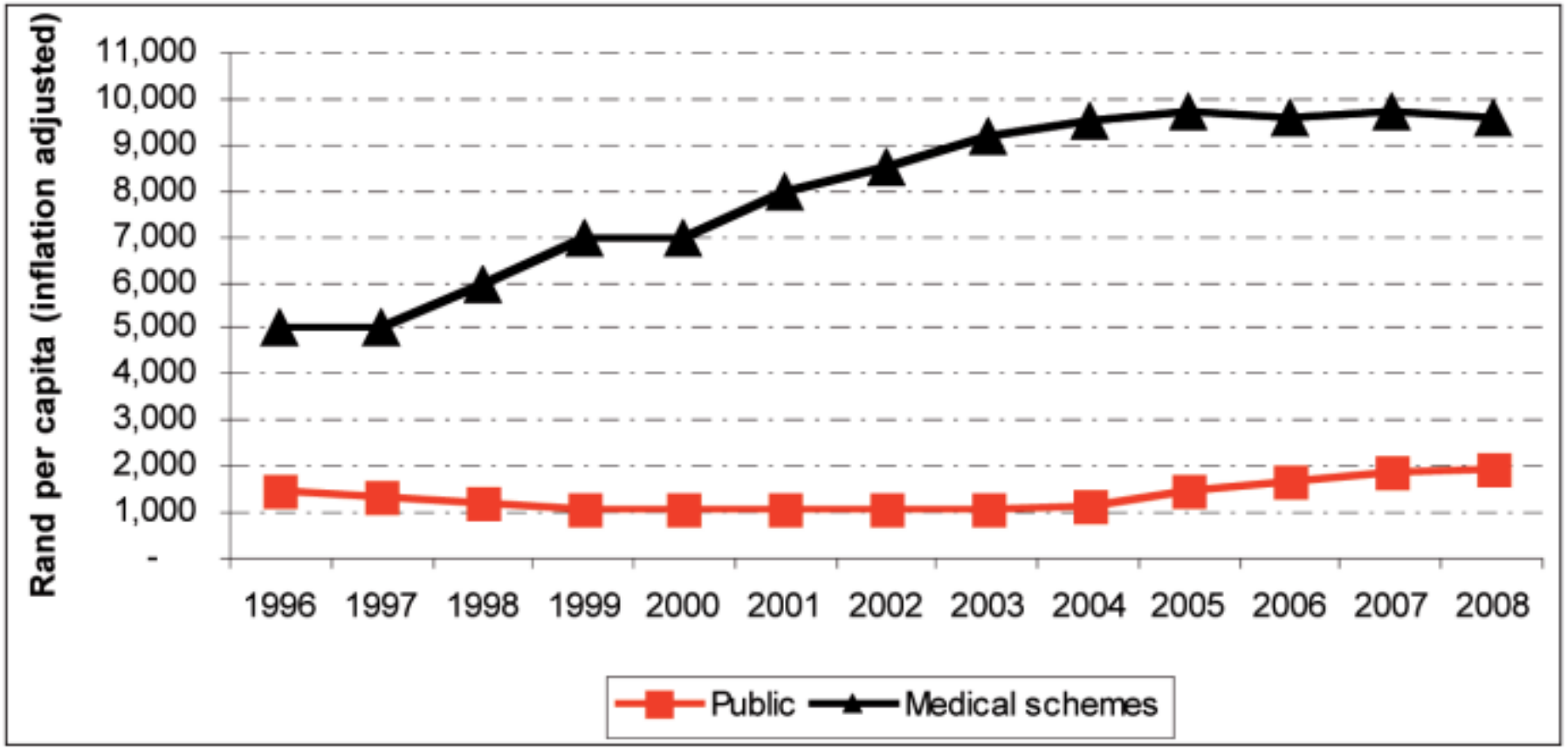
- The late apartheid government and the post-apartheid government fostered an environment that led to a fast-growing private medical sector resulting in nearly half of all financing for health care originating from private payments through medical schemes and OOPs (Department of Health, Republic of South Africa, 2017).
- South Africa spent approximately 8.6 per cent of GDP on health services in 2013/14, with an annual average real increase in spending of 1 per cent a year over the past three years.



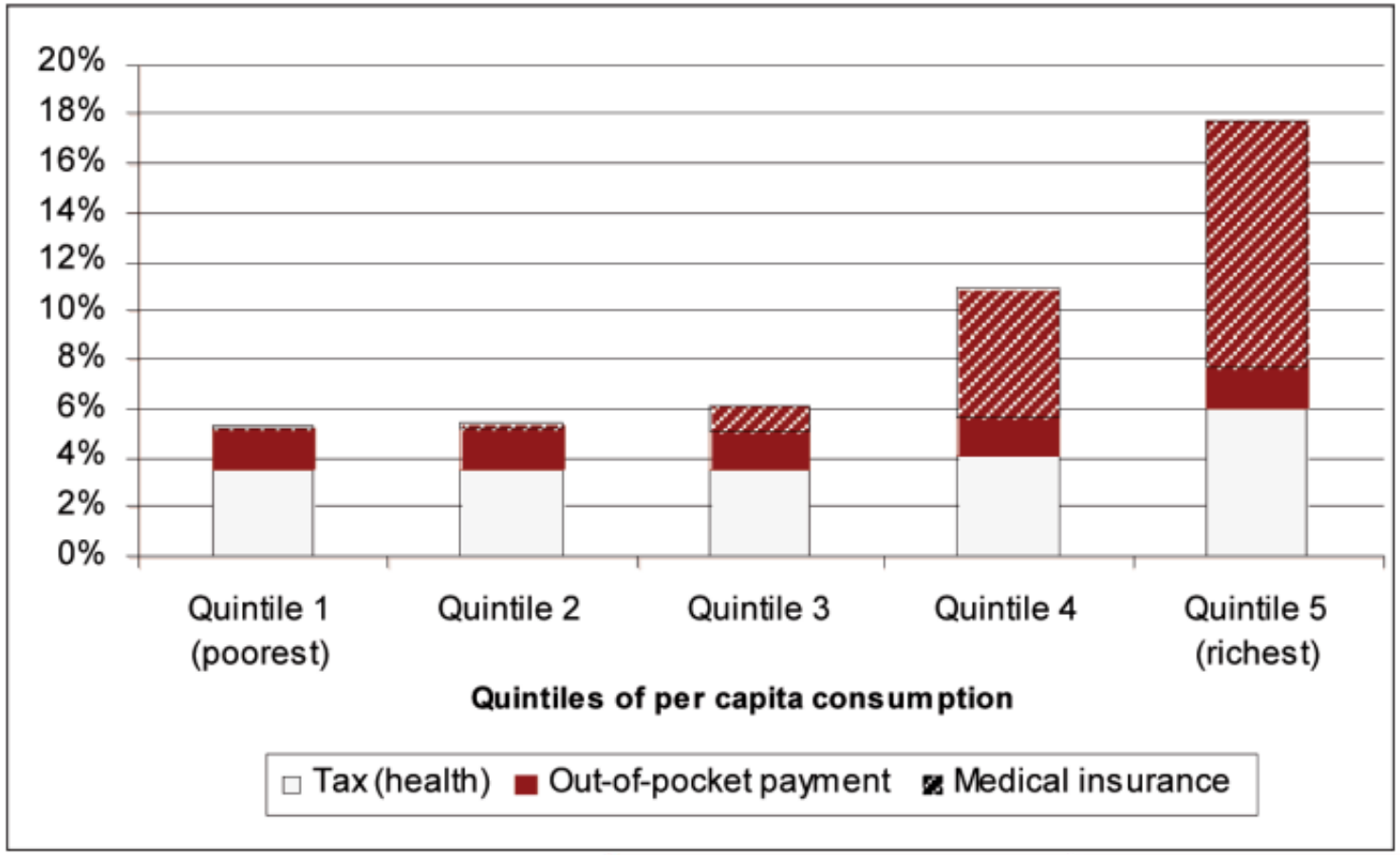
Real per capita (uninsured) public-health expenditure, South Africa (2015/16 prices)



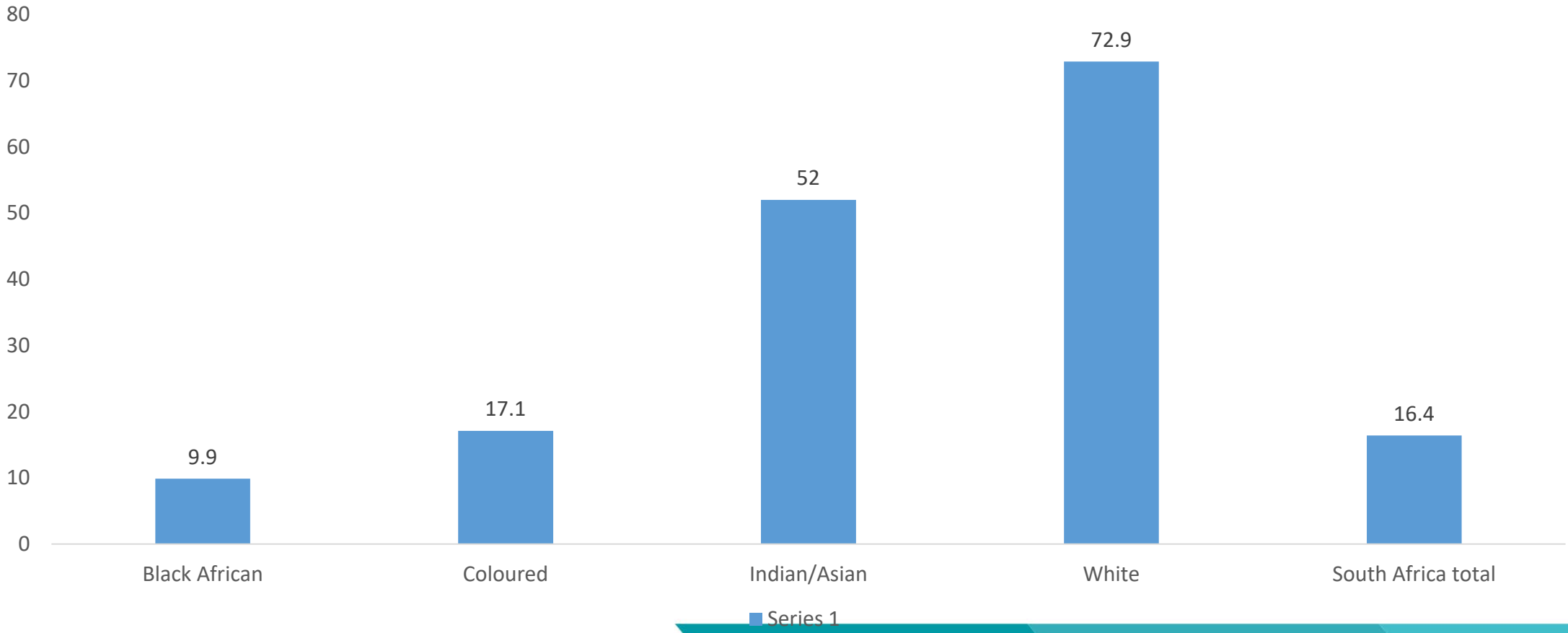
Real per capita spending by medical schemes and the public health sector



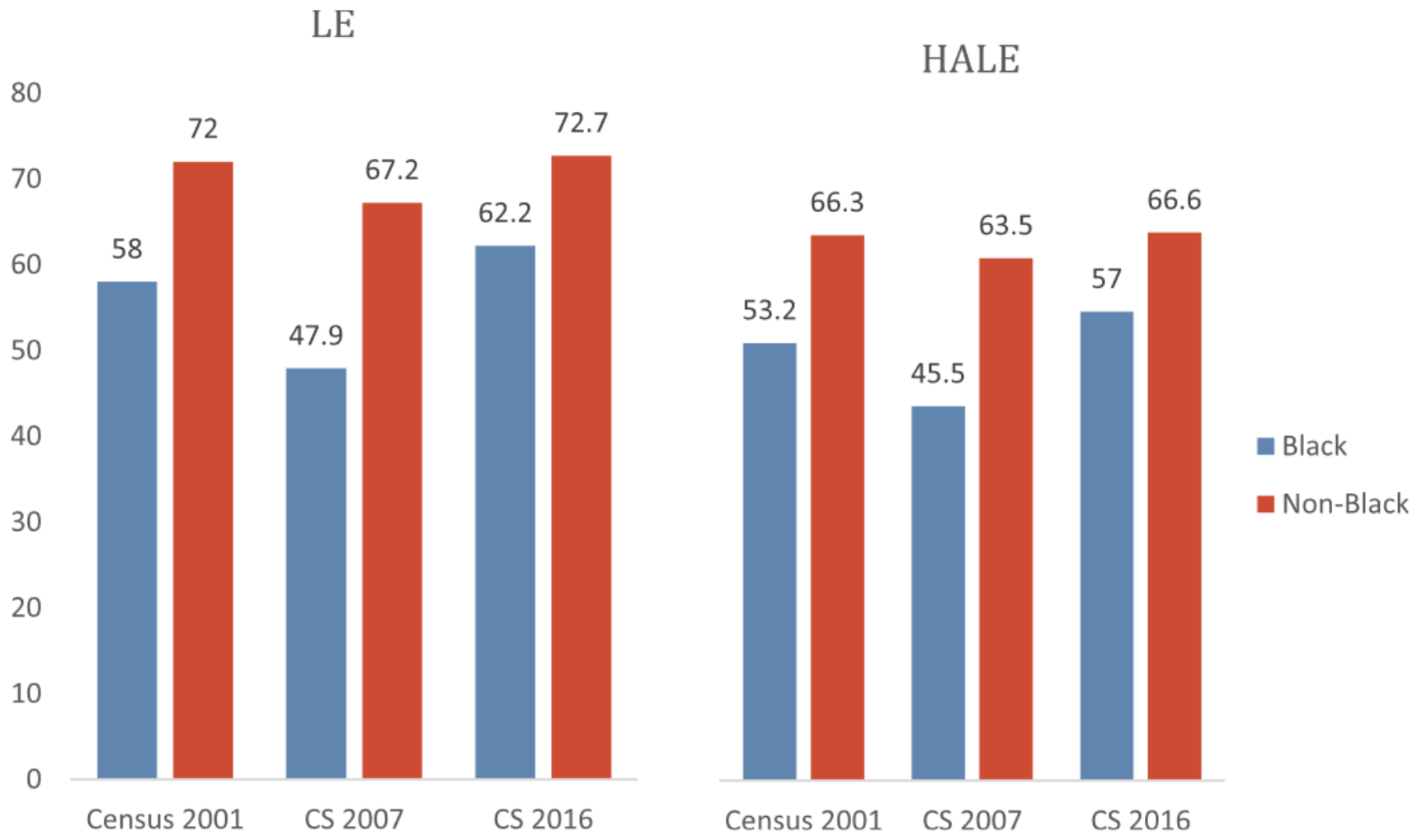
Distribution of total health financing incidence in South Africa



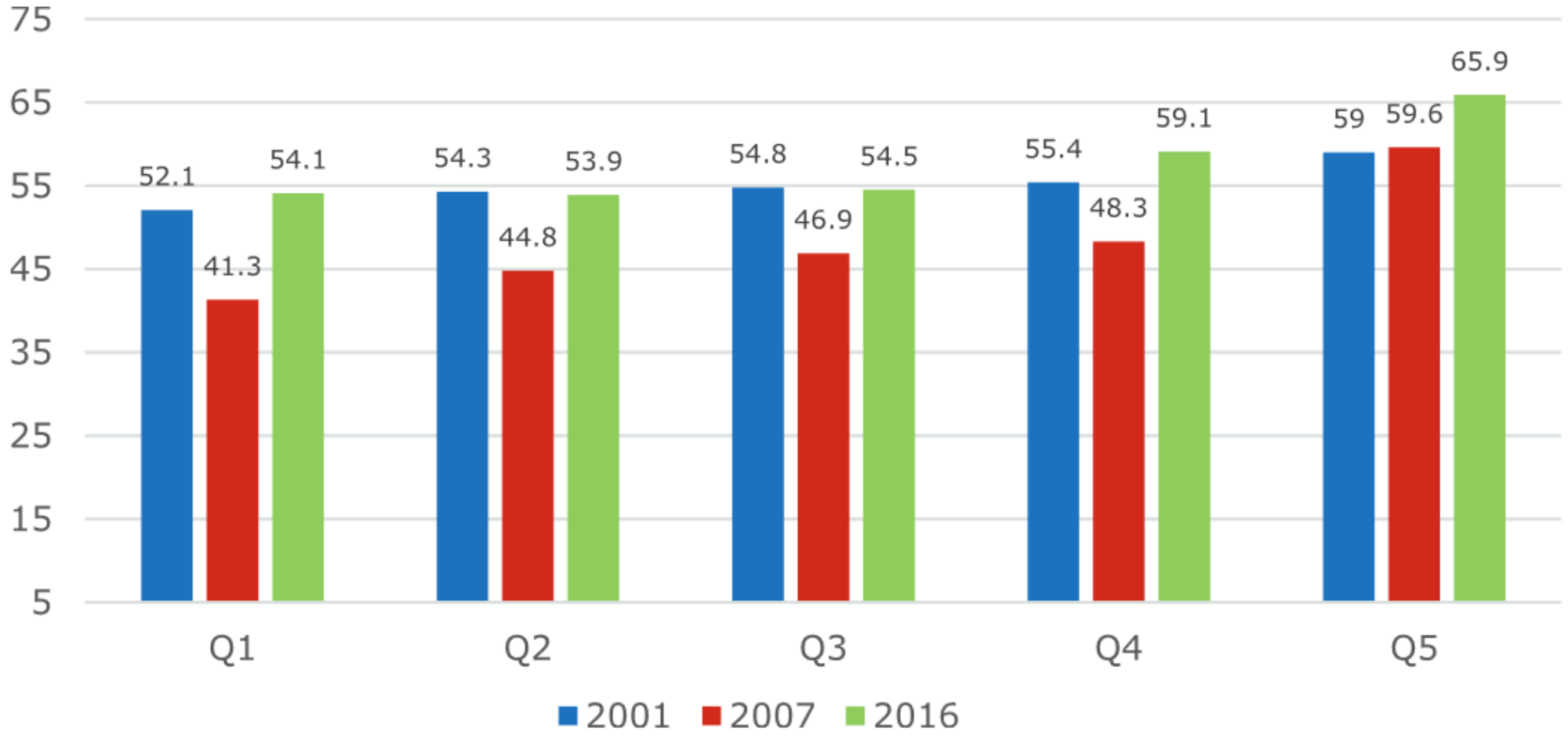
Access to private medical aid by race



Life expectancy and healthy life expectancy at age 5 for the Black South African and non-Black population, 2001, 2007 and 2016.



Health Adjusted Life Expectancy at age 5, by income quintile and year



National health Insurance

- The NHI aligns with the goals of UHC in that it seeks to ensure that the entire South African population has access to good quality medical care and to reduce the direct and out-of-pocket payments that individuals have to make towards health care services (National Department of Health, 2017).
- The NHI will purchase services from the private sector to improve the quality of services.
- Under the NHI, multi-disciplinary referral networks of public and private sector providers will be created to provide a range of health services to all patients.
- The NHI seeks to reduce out-of-pocket payments

National health Insurance: revenue raising

- The South African government will raise revenue for the NHI by reducing the number of services that medical aids may cover. Moving some of this private spending on PHC services towards the NHI.
- The government will remove tax credits to private insurance companies.
- They may also use new types of levies and taxes to raise money for the NHI (payroll and personal income tax??).

National health Insurance: pooling

- The NHI will pool all this money and create a single-payer system that cross-subsidises the rich and the poor and the healthy and the sick.
- The NHI fund will actively and strategically purchase services, medicines and health-related products from accredited private or public providers seeking to create a more efficient health care sector, in terms of costs and delivery.
- One powerful purchaser can determine costs of services.
- However, design of the NHI and the health benefits package has not been finalised yet.

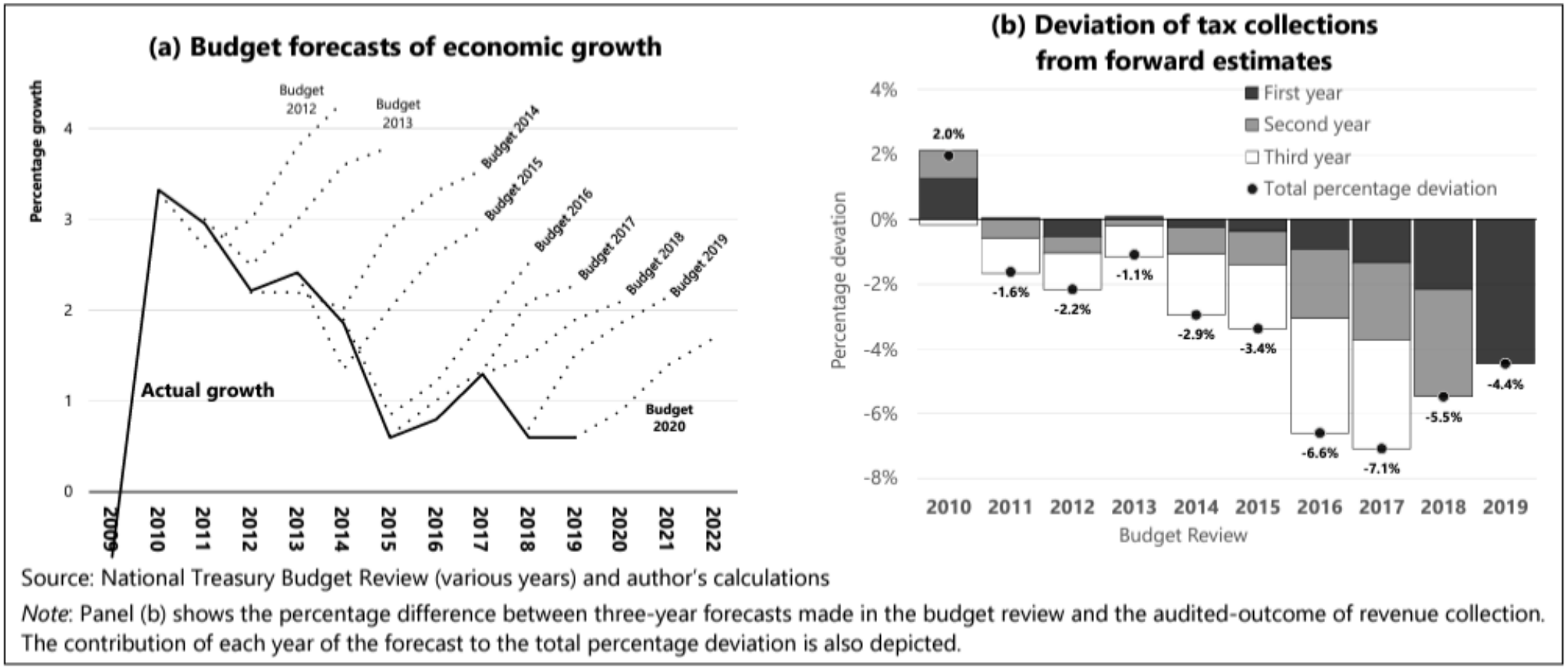
Marketising the health system

Market principle	Market mechanism	In the NHI White Paper
Health care should be open to new actors to finance or offer services.	Shifting costs away from public budgets to private sector.	No
	Financialisation of infrastructure services through PPP or public finance initiatives.	**Not in White Paper, but part of health system**.
	Inclusion of non-traditional actors in health provision.	**Yes**
Public and private sector competition should make the public sector more responsive and efficient.	Use fixed price reimbursement for all providers, for example Diagnosis-related groups.	**Yes**
	Centralised purchasing of health care services and products	**Yes**
	Allow public organisations with severe deficits to go bankrupt instead of bailouts	No
	Public-sector performance management: stimulate competition by benchmarking providers against one another	**Not clear if this will occur. Seems likely given the focus on improving data monitoring systems under the NHI.**
	Allow patients to choose their health care providers.	**Yes**
	Implement competitive tendering for services.	**Yes**
For competition to drive improvements public health care sector needs to engage with customers and competitors (also known as market facing).	Create an internal market with a purchaser-provider split	**Yes**
	Allow hospitals to become more autonomous by allowing hospital CEOs control over their own budgets.	**Yes**
	Decentralisation of regulation to improve the public sector's bureaucracies' responsiveness to local conditions.	**Yes**

The impact of marketisation

- The impact of marketisation on the cost and quality of health care in Europe has been negative (Krachler et al., 2022).
- One study showed that the mechanism used to bring non-traditional providers into the public sector had cost implications and that service provision quality declined.
- Goodair and Reeves (2022) assessed the impact of outsourcing health care services on treatable mortality rates, in the English NHS from 2013 to 2020, showed that outsourcing increased treatable mortality rates and this may have been through the reduction in quality of services provided.
- According to Hermann (2010) the introduction of marketisation has promoted inequality between patients and health care workers and eroded the public nature of health care provision.
- Additionally, the marketisation of health care has led to the movement of funding from public to private health care in Europe (Hermann, 2010).

The South African state in a fiscal crisis



Source: National Treasury Budget Review (various years) and author's calculations

Note: Panel (b) shows the percentage difference between three-year forecasts made in the budget review and the audited-outcome of revenue collection. The contribution of each year of the forecast to the total percentage deviation is also depicted.

Conclusion: Financial coverage in a state in crisis

- Marketisation will increase the costs of delivering public health care.
- The state which is in the midst of a fiscal crisis will struggle to meet its commitments to the public and may reduce its service offerings.
- I argue this will negatively influence financial protection amongst those that can afford to pay for health care and may negatively influence service delivery under the NHI.

How do we improve the performance of the South African health system while keeping costs down?

Provide 4 interventions you would undertake.

HEARD

Thanks

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