Key Features of the Current NHI Proposal

Introduction

In South Africa, the debate surrounding the introduction of a national health insurance scheme (NHI) has returned to centre stage after recent announcements that such a scheme will soon become a reality. The ANC stated in its 2009 Election Manifesto that the NHI would be one of its key priorities. This was confirmed by President Jacob Zuma in his 2009 State of the Nation address. The idea of a national health insurance system is nothing new and the aim of providing universal coverage is one that characterises the health reforms of many developed and developing countries.

The most important issue from an economic perspective is the cost of such a scheme, especially under an assumption of universal access. Some commentators have already warned that the proposed NHI will be massively expensive or even completely fiscally unaffordable. Clearly, there is a need for proper economic analysis of the costs and benefits of NHI in South Africa.

This note is the first of a series of ‘NHI Notes’ that will examine these issues in more detail. The series of research notes will deal with some of the important questions that need to be answered around the viability of a NHI scheme and is aimed at contributing to the debate around costs and optimal design. One of the principal challenges is the lack of transparency in the current process. Originally, the only available documents that provided more detail on the proposed scheme were a (leaked) 200 page ANC document, a (leaked) 68 page ANC policy proposal on National Health Insurance and a 4 page elucidation in ANC Today.

The first concrete steps towards the establishment of a South African NHI were recently taken with the establishment of a National Health Insurance Advisory Committee. Two expected outcomes of the National Health Insurance Advisory Committee are the finalisation of an implementation plan by June 2010 and the eventual implementation of a full NHI system over a five year period.

The aim of this first NHI Note is to understand in more detail what is currently known about the proposed NHI. The following promise appears in the ANC Today summary: ‘Contribution will be less than what members and their employers currently pay to medical schemes. Certain categories of workers, due to their low-income status, will be exempted from the contribution. All these funds would be placed in a single pool that would be available to fund all health care in the public and private health sector under conditions that would apply to all health care service providers’. Such a statement means little if the terminology remains undefined and no detail is available.

In this NHI Note, some of the key features of the proposed NHI plan will be unpacked and commented on. Experiences from countries that have implemented similar health insurance systems will be touched upon to provide an idea of the practical implications involved in the implementation of each of the features mentioned. This will provide a platform to understand the implications of the current proposal and the resources required to achieve these goals.

5. See footnote 4, p.5.
1. Key Features of the Current NHI Proposal

1.1 Publicly Administered and Funded National Health Insurance Authority (NHIA)

The NHI proposal envisages the creation of a single-payer fund by way of a NHIA. This fund will receive funds, pool resources and purchase services for the entire South African population. Funding will be sourced from a combination of employer contributions, employee contributions and existing fiscal funding for healthcare. The employer and employee contributions would require an additional tax for all tax payers and their employers, while the existing fiscal funding for healthcare would continue to be sourced from government’s revenue pool which, in turn, is predominantly funded by income tax contributions. An equal split between employers and employees is envisaged. This planned compulsory employer-employee contribution is currently described in the ANC Today publication as ‘modest’. In addition, certain categories of low-income workers will be exempted from contributions to the NHIA. The ANC Today publication also claims that the NHI will require no additional government spending on healthcare as percentage of GDP, through, amongst other things, the savings on administrative costs and the removal of the current tax subsidy for medical schemes.9

Figure 1 provides a graphical representation of the proposed funding mechanism for the NHI system: Contributions from three sources flow to the NHIA, where funds are pooled and used to purchase services from both public and private healthcare providers. Purchasing occurs on a contracting basis and will include the services offered by hospitals, clinics and medical practitioners.

Furthermore, the current NHI proposal envisages that the creation of a single funder and purchaser of healthcare will translate into cost savings with regards to both the administration and purchasing of healthcare. Savings in administration costs are believed to occur through the advent of a single purchaser of healthcare as opposed to the current multi-payer (medical scheme) system in South Africa. Other cost savings are envisaged through changes in payment methods from funders to providers.

These include negotiated capitation methods for doctors9, global budgeting for hospitals and bulk purchasing of drugs and supplies. An important aspect of an NHI that is not given sufficient attention in the NHI documentation to date is the administration cost and, more importantly, the administrative complexity, involved in managing an organisation of the size the NHIA is likely to be. Health economist, Alex van den Heever, puts the potential costs and complexities of such an organisation in context: ‘Using the South African Social Security Agency as a model, which has a budget of R4-billion per annum, the NHIA, which proposes to engage in vastly more complex activities, is likely to have a minimum budget of at least R8-billion per annum, which is 400% more than the cost of a current district administration budget.’10

The introduction of mandatory insurance (as it appears the South African NHI will be) in itself presents implementation challenges. Clear guidelines for enrolment have to be set and authorities should be in a position where they can enforce these enrolment guidelines. This position becomes even more complicated when more than one

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7. See footnote 3.
8. ‘The current tax deductibility of medical scheme contributions will be removed. This will contribute to increasing tax revenue, which will facilitate the allocation of additional tax funds to the health sector through the NHI Fund’ ANC NHI Task Team (2009:54).
9. Negotiated capitation refers to a situation where medical professionals are not paid on a fee for service basis as is currently the case in the majority of the South African private healthcare market. Rather, a given number of people are assigned to a single health professional or hospital service. The allocation typically occurs through a process of negotiation where remuneration for services to be rendered is agreed.
medical scheme is in existence, either before or after the introduction of NHI. This was also the case in Ghana, where a number of private and commercial schemes remained in operation after the introduction of the Social Health Insurance scheme. 11 While Ghanaian authorities set targets for coverage over a 5 to 10 year period, no indication of how enrolment would be enforced was given, leaving the achievement of these targets an open question. Another potentially problematic area identified in the Ghanaian SHI system was the number of dependents per contributing (working) individual. In Ghana, all dependents are covered even if they are not elderly or children. Fears were raised that this might adversely affect the financial sustainability of the Ghanaian SHI system. 12 All else equal, the total value of contributions from individuals to a SHI system is likely to be equivalent to that of an NHI system in a given country. However, under an NHI system, the number of non-contributing individuals is significantly higher — especially in a country, such as South Africa, with both a high rate of unemployment and a comparatively large informal sector. The implications for the financial sustainability of a NHI authority should not be underestimated.

1.2 Universal Healthcare Coverage and Zero Co-Payments

A central feature of the current NHI proposal is to expand healthcare coverage to the entire South African population. This ties in closely with the premise of social solidarity on which the NHI idea is built, according to which services should be delivered based on need as opposed to the ability to pay. Free access irrespective of the ability to pay naturally requires a great deal of income cross subsidisation between individuals that have the ability to pay for healthcare to those that cannot afford healthcare. This cross subsidisation will be achieved through both the employer/employee contributions and income taxation — contributions will be skewed to the wealthy, while access to healthcare will be universal.

In this regard, one can take note of the experience of Thailand. 13 Universal cover in Thailand was achieved through an extended process of consultation from 1993, when it was first seriously debated, to 2001, when it was finally implemented. More importantly, social health reform in Thailand was already quite developed in 1993, when the issue of universal coverage became a priority. The entire process to achieve universal coverage in Thailand took a few decades to become a reality. Indeed, only two countries in the world have achieved universal coverage in less than 40 years from their first legislation on social health. The two countries are Japan (36 years) and South Korea (26 years). 14 Examples of very long implementation periods for universal coverage include Germany (127 years) and Belgium (118 years). The current ANC NHI proposal is the first attempt at legislation on social- or national health insurance in South Africa. Also, the period currently suggested for the implementation of South African NHI is 5 years, an optimistic target by any standard.

Still, the experience of Thailand does indicate some important challenges for South Africa: The first of these was to identify those individuals that needed to be insured and then to put the systems in place to register all covered individuals.

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11. Social Health Insurance (SHI) differs from National Health Insurance (NHI) in that it covers only those individuals (and their dependents) that are employed. These individuals make contributions to the scheme and, in turn, receive benefits. Unemployed (non-contributory) individuals and their dependents are typically not included in a SHI scheme, but may have access to affordable medical services through other government programmes. The level of income cross subsidisation in an SHI scheme is, therefore, likely to be significantly less than under a NHI system.


13. See footnote 12.

Thailand had to cover a total of close to 50 million people, a figure comparable to the current South African population. A related problem was the reform of provider payment that accompanied universal coverage. As is the case with the current proposal in South Africa, Thailand decided on a capitation payment mechanism. The capitation payment had to be sufficient to encourage private healthcare providers to sell their services to a NHIA.

Another feature of the current South African NHI proposal is the concept of zero co-payments with all services covered under the benefit package of the NHI.\(^\text{15}\) This feature implies that access to healthcare will not require any initial payments, with the only healthcare services that will require an upfront payment being those that are not covered under the NHI package, currently mostly cosmetic procedures.

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payment with services rendered and will be free to all South Africans at the point of service. This situation can be compared to universal general insurance with no ‘excess’ payable on claims. Taking current healthcare provision in South Africa as a starting point, a newly introduced comprehensive benefit package with zero co-payments is bound to result in a dramatic increase in the demand for the whole range of medical services. Given the current stock of especially medical professionals, but also other finite resources, it is inevitable that a major increase in the demand for healthcare will require some form of rationing to match demand with supply. The rationing of healthcare within an NHI system is an important aspect in the South African context and will be returned to in a later NHI Note.

1.3 Comprehensive Benefit Package

A comprehensive range of health benefits is suggested, including primary care, inpatient and outpatient care, dental, prescription drugs and supplies. More precisely, the ANC policy proposal on NHI lists the following services as part of the standard NHI benefit package:

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

Such a comprehensive benefit package will be a significant improvement on what is currently offered in South Africa through the public health system. In Ghana, questions have been raised about the costing of their mandatory benefits package and how this will affect the long run financial sustainability of their SHI system. The broad range of services, covering almost all care except certain chronic diseases is seen as too extensive, especially considering the expected increase in utilisation of healthcare services when the system is fully operational. This is also likely to be the case in South Africa if an extensive list of services is offered under an NHI system without full consideration of the financial implications. Referring again to Figure 1, this equates to a larger than expected flow of services from both private and public healthcare providers to the South African public.

1.4 Publicly and Privately Delivered Healthcare

Healthcare services will be delivered by both private and public healthcare providers and funded by the NHIA. All service providers will have to be accredited by the NHIA, based on predetermined criteria. This service delivery model is shown in Figure 2: Private and public healthcare providers (including facilities and medical professionals) are contracted by the NHIA. In turn, contracted healthcare providers render their services to both contributing and non-contributory households, based on the principal of universal access on a capitation basis. Contributions are made to the NHIA according to the various channels shown in Figure 1 (employer contributions, employee contributions and other government income).

An important point in this regard is that private healthcare providers cannot be mandated to sell their services to an NHIA. As was mentioned earlier in the case of Thailand, the level of capitation remuneration under an NHI system has to be sufficient to convince private healthcare providers to contract with the NHIA and provide good quality healthcare at the agreed upon capitation price. There will also be no differentiation in the price paid to private and public healthcare providers, implying that the market price will have to converge to the price level needed to attract the services of private healthcare providers. At the same time, the level of remuneration has to be affordable enough to make the NHIA financially sustainable. Balancing the financial sustainability of an NHIA with the ability to contract quality healthcare services from private healthcare providers is a difficult task at the best of times.

In the South African context, the above mentioned task can be considered even greater due to two major contributing factors. Both of these can be explained by way of Figure 2: Firstly, the supply of quality healthcare from public healthcare providers is quite limited and the NHIA will have to acquire a substantial portion of services from private healthcare providers. As such, remuneration will have to be set sufficiently high to induce these providers to sell their services to the NHIA. This
factor will determine the private-public mix of provider contractor and payment shown in Figure 2 and any corresponding flow of services from healthcare providers to the South African public. The second major factor that will come into play in the South African context is the size of the ‘contributing individuals’ pool compared to the pool of ‘non-contributing individuals’. If the aggregate demand for healthcare services is substantially more than contribution flows to the NHIA, this will place increased pressure on the financial sustainability of the NHIA in the absence of very large transfers from other government resources.

2. Conclusions

This NHI Note provided a brief overview of some of the key features of the South African NHI proposal that have been made public thus far. These include the creation of a publically funded and administered National Health Insurance Authority (NHIA); extending cover universally; the provision of a comprehensive benefit package; and the use of a combination of public and private healthcare providers to deliver the before mentioned services. Apart from describing the details of each of these concepts, a variety of country comparisons were employed to illustrate the practicalities of implementing the features in question. It was shown that while many of the current suggestions for the South African NHI are based on admirable principles such as social solidarity, the actual implementation involves a number of complicating factors. Further notes in the Econex NHI Note series will expand on some of the issues identified in the current note as well as other important questions relating to the NHI proposal. The series will culminate with a number of costing scenarios required for a comprehensive NHI system in South Africa.