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Transforming the funding of health care in South Africa: A taxation perspective

By

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ABSTRACT

Transforming the funding of health care in South Africa: A taxation perspective

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The tax system in South Africa makes provision for everyday South African citizens to contribute to a greater or lesser extent towards health care funding in South Africa. However, as a result of the high unemployment rate, a large gap exists between tax contributors and non-tax contributors. This raises the question of whether it is fair that the burden to fund the proposed National Health Insurance (NHI) initiative in South Africa is borne by the small percentage of current tax contributors.

The purpose of this research was to provide a taxation perspective on the different funding models and financing options available to the South African government for consideration in developing the NHI implementation strategy.

The study evaluated the four traditional health care models used worldwide and assessed existing health care systems in selected first and third world countries in order to contribute towards the development of the proposed NHI system in South Africa. The health care models used by France, The United States, The United Kingdom, Brazil and Spain were evaluated in order to achieve an understanding of the funding approaches followed by these countries.

It was found that although it is inevitable that South African tax contributors will have to be more heavily taxed in order to fund the NHI, as there are only limited possibilities for distributing the tax burden evenly. The main stumbling block in finding an equitable funding solution is the fact that there is a large disparity in South African income tax contributors.

KEYWORDS:

- National Health Insurance
- Health care models

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- Health care funding
- Increased tax burden
- Tax contributors
- Unemployment

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CHAPTER 1

INTRODUCTION, OBJECTIVE AND PROBLEM STATEMENT

1.1 INTRODUCTION AND BACKGROUND

The 1978 Declaration of Alma Ata was a ground-breaking event as it linked the right to health services for all to a viable strategy for the implementation of primary health care systems in countries around the world (UNICEF, 2009).

This Declaration, which was signed by 134 countries and 67 non-governmental organisations, aimed to reduce health inequalities between and within countries, thereby achieving the ambitious but hitherto unrealised goal of 'Health for All' by the year 2000. These health care services were to be universally accessible to individuals and families at a cost that communities and nations as a whole could afford (UNICEF, 2009).

The Alma Ata Declaration urged governments to formulate national policies to incorporate primary health care into their national health systems (World Health Organisation, 1978).

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Albeit 33 years later, on 12 August 2011, a South African National Health Insurance (NHI) scheme became a possibility when the then Minister of Health, Dr Aaron Motsoaledi, published the Green Paper on National Health Insurance in the Government Gazette, no 34523. This was the first step in the South African government's introduction of universal health care in South Africa (Department of Health, 2011a).

Although the possibility of a mandatory health insurance scheme in South Africa was first raised by progressive academics in the early 1990s, the first time government actually incorporated this vision into a formal policy document was in the African National Congress's National Health Plan (McIntyre & Van den Heever, 2007).

According to the World Health Report of 2010, promoting and protecting health is essential to human welfare and sustained economic development. 'Health for All' would contribute both to a better quality of life and to global peace and security (World Health Organisation, 2010).

The term 'universal health care', however, has different interpretations and most countries around the world form their own understanding of what this concept entails.

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Torrey (2013) defines the concept of universal health care or universal coverage as a scenario whereby all the legal citizens of a country are covered for basic health care services, and no-one is denied care as long as they are legal residents in the geography covered.

Universal health care usually refers to a system which provides health care services for all citizens of a country whilst protecting people from the financial consequences of medical expenditure. Universal health care is structured around the provision of a specified package of benefits to all members of society, together with the end goals of financial risk protection, improved access to health services, and thus, improved health outcomes (World Health Report, 2010).

One of the important factors to consider is whether South Africa will actually be able to afford a health care system that can satisfy the needs of the 'rainbow nation'. Although the NHI is a compelling vision, it is widely known that due to the high rate of unemployment, South Africa has a large gap between tax contributors and non-contributors (McIntyre & Van den Heever, 2007).

One of the important questions that will therefore be raised in this study is whether the introduction of a National Health Insurance scheme would be fair to all the people in this country. This study will investigate the additional tax burden South African citizens would have to bear, should such a system be implemented.

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The Minister of Health, Dr Motsoaledi, remarked that there are two major problems confronting the South African public: the poor quality of care in the public sector and soaring costs in the private sector (Department of Health, 2011a).

According to the 2012 Budget Speech (National Treasury 2012), the proposed NHI scheme is to be implemented over a fourteen-year period. More than two years later, the long-awaited White Paper which was to provide guidance on the implementation and funding of the proposed NHI scheme has yet to be released. What is clear, however, is that extra funding will need to be raised over and above the current public health care budgets in order to provide equal health cover for the entire South African population.

Head of Healthcare services at KPMG, Mr Sven Byl, analysed the cost estimates of the roll-out of NHI in South Africa. In KPMG's economic analysis of the NHI, Mr Byl estimated that the NHI would cost an average of R10.4 billion every year, over and

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above what is currently spent on public health care. This totals to R145 billion over the fourteen-year implementation phase (KPMG, 2011).

It is evident that South Africa desperately needs new ideas on financing the NHI scheme. Slowly but surely, South Africa is building a better understanding of what national health is and why such a system must be implemented (Matsoso & Fryatt, 2013).

1.2 MOTIVATION

In the initial Green Paper published by the South African government in August 2011, it was emphasised that the goal of national health insurance in South Africa would be a financing system that would ensure that every South African citizen, including long-term residents, would have access to vital health care, irrespective of their employment status or ability to contribute to the NHI fund (Department of Health, 2011a).

Funding of universal health care has always been a sensitive and topical issue in many countries around the world. Implementing an efficient yet affordable system in South Africa that would provide comprehensive services to those that need them most, namely the poor and the marginalised, would be quite a balancing act.

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1.3 PROBLEM STATEMENT

A South African health care reform is imminent. The funding of this expected transformation will have serious financial implications for the South African government as well as all its citizens. The economic viability of such a reform needs to be assessed from a taxation perspective in order to determine the best funding options available to ensure the successful implementation of a National Health Insurance scheme in South Africa.

1.4 RESEARCH OBJECTIVES

Main Objective

The main objective of this study is to provide a taxation perspective on the different funding models and financing possibilities available to the South African government for consideration in developing the NHI implementation strategy. The main objective will be addressed by exploring the secondary objectives outlined below.

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Secondary Objectives

- To examine the different health care models that exist internationally;
- To compare national health insurance models implemented in selected first and third world countries;
- To provide recommendations to the South African government on the implementation and funding of a National Health Insurance scheme in South Africa.

1.5 RESEARCH METHOD

1.5.1 Literature review

A literature review is used to establish the theoretical roots of the study, clarify ideas and develop the methodology (Kumar, 2005). The research will rely to a significant extent on a literature review of journal articles, internet sources, textbooks and government releases on the subject. As the South African NHI proposal unfolds, there has been ongoing debate and regular input by various role players about the advantages and disadvantages of NHI in South Africa. The research will be conducted in the form of an extended argument supported by critically evaluated existing literature and documentary evidence.

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1.5.2 Comparative analysis

All health care systems worldwide are wrestling with problems of rising costs and lack of access to care (Tanner, 2008). It is thus appropriate to conduct a comparison between government funding and public contributions towards national health systems in other first and third world countries around the globe.

1.6 LIMITATIONS

Unless otherwise stated, this study will only focus on health care provision and funding of the selected countries with regards to citizens and long term residents of that country. This study will deem foreigners and illegal immigrants to fall outside the scope of government funded health care and their medical expenditure will be regarded as out-of-pocket payments.

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1.7 CHAPTER OVERVIEW

In order to achieve this research goal and to address the problem statement, this topic will be addressed and evaluated in the following chapters.

CHAPTER 1: INTRODUCTION, OBJECTIVE AND PROBLEM STATEMENT

This chapter serves as an introduction to the topic of national health insurance in South Africa and around the world. The term 'universal care' is discussed with reference to the Alma Ata Declaration of 1978; the background to health care in South Africa and the proposed implementation of the National Health Insurance scheme in South Africa is also discussed in this chapter.

CHAPTER 2: NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

This chapter will investigate the viability of a national health insurance model in South Africa. Discussion points will include the advantages and disadvantages of the proposed reform, as well as a detailed review of possible funding for such a system in South Africa. This chapter will also include an overview of the Green Paper, published by the Minister of Health in 2011, which introduced the possibility of a national health insurance model in South Africa for the first time.

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CHAPTER 3: NATIONAL HEALTH CARE MODELS

This chapter will analyse the four health care models that form the basis of all health care systems used around the world. These are the Beveridge model, which is a state-funded system, the Bismarck model, which is a social health insurance system funded by insurance schemes, the National Health Insurance Scheme, which is a combination of the Bismarck and Beveridge models, and lastly, the Out-Of-Pocket model, which is used by countries that have no centralised health care system. The choice of model by a given country is based on its history, politics, economy and national values.

CHAPTER 4: NATIONAL HEALTH IN FIRST WORLD COUNTRIES

This chapter investigates health care systems in other countries around the world. It examines the health care systems of three first world countries, namely France, the United Kingdom and the United States of America. These countries have all implemented sophisticated health care systems over many decades; South Africa can

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learn from their experience in ensuring that a sustainable national health insurance approach is devised for South Africa.

CHAPTER 5: NATIONAL HEALTH IN THIRD WORLD COUNTRIES

Chapter 5 forms an important part of the comparison of health care systems as it specifically investigates health care systems in selected developing countries. South Africa can eliminate a great number of health care stumbling blocks by avoiding the pitfalls faced by other third world countries. The health care systems of Brazil will be analysed as, together with South Africa, it is part of the BRICS forum countries. The health care system of Spain will also be examined since both Brazil and Spain share certain socio-economic burdens with South Africa. The results of the comparison will be discussed in order to provide recommendations on how to solve these problems in a South African context.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

This chapter will serve as the conclusion to the study where key deductions and recommendations will be discussed, based on the analysis of literature in Chapters 2 to 5. Chapter 6 will reiterate the problem statement and the research objectives and conclude the findings of the study.

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CHAPTER 2

NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

2.1 BACKGROUND TO THE SOUTH AFRICAN HEALTH SYSTEM

This chapter provides an overview of the South African health system as it has evolved over the past decades. This chapter will discuss the status of the national health system, with reference to South Africa's health care history, the current situation, the proposed National Health Insurance scheme and its funding in the future.

The Department of Health (2011a) explains in its Policy Paper on National Health Insurance, published on 12 August 2011, that prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. According to the Policy Paper, one system was well-resourced and benefitted the white minority. The other was under-resourced and was for the black majority. The South African Constitution has since outlawed any form of racial discrimination and strives to ensure that every citizen has an equal right to health care.

Since the start of the new South Africa, there were many attempts to transform the health care system although these attempts were met with little success. This has led to the development of a two-tiered health system which is currently in place in South Africa. These two tiers, namely private health care and public health care, operate very differently and are based primarily on socio-economic status. This unfortunately continues to uphold the inequalities inherent in the current health system (Department of Health, 2011a).

Gilson and McIntyre (2007) further confirm the existence of these two tiers in the current health care system in South Africa. They summarise the two sectors as follows:

- **Public Health Sector**

  The public health sector refers to medical services offered mainly by national, provincial and local government. These services are mostly funded from national taxes.

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- **Private Health Sector**

  The private health sector consists of all medical services offered by general practitioners, specialists, pharmacists and private hospitals outside the government sphere. These providers are mainly funded through medical schemes and out-of-pocket payments.

Having defined these two sectors, it is important to note that the consistent under-performance of the South African public health care system has resulted in a significant split between public and private health care in the country (Naidoo, 2008).

This is confirmed by the Council for Medical Schemes (CMS) that states that medical schemes are the major purchasers of services in the private sector, which covers only 16.2% of the population (CMS, 2012). This results in the other tier, namely public health care, providing medical services to the bulk of the population which cannot afford private health care. Public health care is funded solely through the fiscus (Kautzky & Tollman, 2008).

It is therefore clear that there is a great disparity in South Africa between the two health care systems. According to the Department of Health, most financial and human resources for health are located within the private sector, serving a minority of the population (Department of Health, 2011a).

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The Policy Paper published by the Department of Health states that the South African government is of the opinion that the current health system is inequitable. According to the Department of Health, the privileged few who can afford private health care, have disproportionate access to health services. (Department of Health, 2011a)

During a national health insurance conference held at Gallagher Estate in December 2011, it was found that the South African health system was inequitable, and therefore unjust. During the conference, attendees were of the opinion that health finance in South Africa was not universal and marginalised the poor and the disadvantaged. The outcome of the two-day conference emphasised the moral obligation to change the South African health system for the better (Department of Health, 2011b).

2.2 NATIONAL HEALTH INSURANCE

Section 27 of the Constitution (1996) of the Republic of South Africa clearly states that all citizens are entitled to access to health care and that the State has an explicit obligation to ensure that this right is progressively achieved, within the resources available.

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In a recent article in the South African Medical Journal, Matsoso & Fryatt (2013) confirms that according to the Green Paper published by the Department of Health, the objectives of National Health Insurance (NHI) scheme are as follows:

1. To increase access to quality health services for all South Africans, irrespective of whether they are employed or not.
2. To achieve equity and social solidarity through the creation of a single fund that will pool risks and funds.
3. To obtain services on behalf of the entire population and competently mobilise and control key financial resources.
4. To strengthen the under-resourced and strained public sector so as to improve the performance of health systems.

It is thus clear that the South African government is hoping to orchestrate change, particularly in the public health sector. The proposed National Health Insurance scheme is seen as a South African dream which will provide better access to quality health care for all South African citizens.

Such a system can only be successfully implemented, however, if the government takes into consideration certain stumbling blocks that South Africa is currently facing.

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2.2.1 South African stumbling blocks

The viability of a South African National Health Insurance scheme has been widely debated by different role players in the medical industry. The following section discusses certain key constraints currently facing the South African government and the Department of Health.

- **The burden of disease**

  The introduction of NHI must take into account the unfortunate burden of disease South Africa is experiencing. Coovadia, Jewkes, Barron, Sanders & McIntyre (2009) explain that South Africa has four concurrent epidemics. These are:

  - HIV/AIDS and Tuberculosis;
  - Maternal, infant and child mortality;
  - Non-communicable diseases; and
  - Injury and violence.

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This situation is described by the Lancet Report as the quadruple burden of disease South Africa is facing (Coovadia *et al*, 2009).

The Department of Health Policy Paper (2011a) mentions that although South Africa has only 0.7% of the world's population, 17% of people infected with HIV in the world reside in this country. The HIV prevalence is therefore twenty-three times the global average.

Taking these facts into account, South Africa must give consideration to this burden of disease when calculating the implementation costs of the NHI scheme.

- **Current economic environment**

Raising additional taxes in order to fund the proposed National Health Insurance scheme will have major repercussions on the economy, particularly since the economy is already dwindling due to the recent recession (Broomberg, 2009).

Consumers are struggling to make ends meet, with continuously rising fuel prices, interest rate hikes and the South African economy struggling due to deteriorating exchange rates (Jones & Anetos, 2014).

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All of these economic factors would complicate an amicable solution to funding the NHI. The reality of the economic situation could therefore hinder the implementation of an all-inclusive package of benefits for all South African citizens.

- **Unemployment**

According to Statistics South Africa (2014), unemployment levels in South Africa were at 25.5% at the end of the second quarter of 2014. This means that more than one out of every four South Africans in the labour force is currently unemployed. The table below shows unemployment rates for all OECD countries. According to the Organisation for Economic Co-operation and Development (OECD) Stat Extract (2014), the average OECD country unemployment rate at the end of 2013 was 7.6%. That is less than a quarter of South Africa's current unemployment rate.

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Subject	Harmonised unemployment (monthly), Total, All persons													
Measure	Level, rate or quantity series, s.a.													
Frequency	Quarterly				Monthly									
Time	Q1-2013	Q2-2013	Q3-2013	Q4-2013	May-2013	Jun-2013	Jul-2013	Aug-2013	Sep-2013	Oct-2013	Nov-2013	Dec-2013	Jan-2014	Feb-2014
Country														
Australia	5.49	5.61	5.73	5.81	5.55	5.73	5.69	5.78	5.71	5.77	5.79	5.87	5.99	6.05
Austria	4.93	4.70	4.97	5.00	4.60	4.70	4.90	5.00	5.00	5.00	5.00	5.00	4.90	..
Belgium	8.30	8.40	8.43	8.47	8.40	8.40	8.50	8.40	8.40	8.40	8.50	8.50	8.50	..
Canada	7.10	7.13	7.07	7.03	7.10	7.10	7.20	7.10	6.90	7.00	6.90	7.20	7.00	7.00
Chile	6.23	5.91	5.50	6.14	5.91	5.51	5.46	5.50	5.75	5.93	6.14	6.52	..	..
Czech Republic	7.23	6.90	6.90	6.77	7.00	6.60	6.90	6.90	6.90	6.70	6.80	6.80	6.80	..
Denmark	7.23	6.80	7.03	6.97	6.80	6.70	7.00	7.20	6.90	6.90	6.80	7.20	7.00	..
Estonia	9.23	8.20	8.50	..	8.20	8.10	8.10	8.50	8.90	9.10	9.30	..	..	..
Finland	8.07	8.10	8.13	8.27	8.10	8.10	8.10	8.10	8.20	8.20	8.30	8.30	8.30	..
France	i 10.80	10.77	10.87	10.80	10.70	10.80	10.90	10.80	10.90	10.80	10.80	10.80	10.90	..
Germany	5.40	5.33	5.27	5.13	5.30	5.30	5.30	5.30	5.20	5.20	5.10	5.10	5.00	..
Greece	26.63	27.40	27.60	..	27.50	27.50	27.60	27.50	27.70	27.70	28.00	..	..	..
Hungary	10.93	10.40	10.07	9.20	10.40	10.40	10.20	10.00	10.00	9.50	9.30	8.80	..	..
Iceland	5.60	5.60	5.57	5.50	5.60	5.60	5.60	5.60	5.50	5.50	5.50	5.50	5.50	..
Ireland	13.73	13.67	12.80	12.20	13.80	13.50	13.10	12.70	12.60	12.40	12.20	12.00	11.90	..
Israel	i 6.59	6.72	6.00	5.77	6.71	6.64	6.14	5.96	5.90	5.84	5.59	5.87	5.87	..
Italy	11.87	12.10	12.33	12.67	12.20	12.10	12.10	12.40	12.50	12.50	12.80	12.70	12.90	..
Japan	4.20	4.03	4.00	3.87	4.10	3.90	3.90	4.10	4.00	4.00	3.90	3.70	3.70	3.60
Korea	3.20	3.13	3.10	3.03	3.20	3.10	3.20	3.10	3.00	3.00	3.00	3.10	3.20	..
Luxembourg	5.57	5.80	5.97	6.07	5.80	5.90	6.00	5.90	6.00	6.00	6.10	6.10	6.10	..
Mexico	i 4.98	5.09	4.90	4.76	5.11	5.03	4.85	4.90	4.97	4.89	4.63	4.76	4.82	..
Netherlands	6.20	6.63	7.00	6.97	6.60	6.80	7.00	7.00	7.00	7.00	6.90	7.00	7.10	..
Norway	3.60	3.43	3.50	3.50	3.50	3.30	3.60	3.50	3.40	3.40	3.50	3.60	..	..
Poland	10.60	10.50	10.23	10.07	10.50	10.40	10.30	10.20	10.20	10.10	10.10	10.00	9.90	..
Portugal	17.53	16.93	16.07	15.43	16.90	16.60	16.30	16.10	15.80	15.60	15.40	15.30	15.30	..
Slovak Republic	14.20	14.27	14.27	13.97	14.20	14.40	14.30	14.30	14.20	14.10	14.00	13.80	13.60	..
Slovenia	10.50	10.60	9.83	9.90	10.70	10.30	10.00	9.80	9.70	9.70	9.90	10.10	10.20	..
Spain	26.50	26.40	26.47	26.13	26.40	26.40	26.50	26.50	26.40	26.30	26.20	25.90	25.80	..
Sweden	8.10	8.03	7.93	7.97	7.90	7.90	7.80	8.00	8.00	7.90	8.00	8.00	8.20	..
Turkey	8.40	8.67	9.10	..	8.70	8.70	9.00	9.10	9.20	9.00	8.90	..	..	..
United Kingdom	7.77	7.67	7.57	..	7.70	7.60	7.70	7.60	7.40	7.20	7.20	..	..	..
United States	7.70	7.50	7.23	6.97	7.50	7.50	7.30	7.20	7.20	7.20	7.00	6.70	6.60	6.70
Euro area (18 countries)	12.00	12.10	12.10	12.00	12.10	12.10	12.10	12.10	12.10	12.00	12.00	12.00	12.00	..
European Union (28 countries)	11.00	10.93	10.90	10.80	10.90	10.90	10.90	10.90	10.90	10.80	10.80	10.80	10.80	..
OECD - Total	8.05	7.97	7.89	7.72	7.97	7.94	7.90	7.90	7.86	7.82	7.71	7.63	7.60	..

Figure 2.1: Unemployment levels in OECD countries

Source: Adapted from OECD Stat Extract (2014)

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Dr Jonathan Broomberg, CEO of Discovery Medical Scheme, also emphasised this fact in an online article on NHI. According to Broomberg, a relatively small number of employed taxpayers would have to carry the cost of providing the envisaged package of health care benefits for the entire population (Broomberg, 2009).

This would mean that in order to fund the NHI, the burden on South African taxpayers would be considerably greater than on citizens in more developed countries with much lower unemployment rates, and therefore more tax contributors.

- **Rising Costs**

Michael Tanner mentions in his research paper, *The Grass is Not Always Greener: A Look at National Health Care Systems Around the World,* that all health care systems worldwide are wrestling with the problems of rising costs and lack of access to care (Tanner, 2008).

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This is a phenomenon that can be seen around the world and South Africa is certainly not exempt. Chris Bateman writes in the South African Medical Journal (SAMJ) that South African medical aid schemes have seen a threefold increase in the use of expensive medical interventions over the last decade. According to Bateman, this is due to the 'explosion' of new drugs, procedures and technology and the increased prevalence of disease (Bateman, 2011).

In the 2014 Budget Speech, the then Minister of Finance, Mr Pravin Gordhan, iterated that the NHI could only be implemented in South Africa once two fundamental pillars were put into place. Firstly, improvements would have to be made to public sector health delivery. Secondly, the high cost of private health care would have to be reduced (National Treasury, 2014).

This statement by the Minister of Finance confirms that the rising costs of health care would first have to be dealt with to ensure the successful implementation of a national health care system in South Africa.

2.2.2 Health care funding in South Africa

It is important to note that according to McIntyre (2009), South African health care is currently funded from three main sources:

- **General tax funds:** This is money collected by government through various forms of tax, namely income tax, Value Added Tax (VAT) and other taxes.

- **Contributions to medical schemes:** Monthly payments made by individuals or their employers to a medical scheme.

- **Out-of-pocket payments:** Payments made directly by patients to a health care provider of their choice, or payments for services which were not fully covered by the patient's medical aid.

McIntyre (2009) further states that it is international practice to evaluate the distribution of the burden of health care funding by assessing health care contributions relative to a person's income. According to McIntyre, it is generally accepted that higher-income groups should spend more on medical expenditure than lower-income groups.

Amado, Christofides, Pieters and Rusch (2012) draw attention to the fact that the World Health Organisation recommends that countries should annually spend at least 5% of their total Gross Domestic Product (GDP) on health care. South Africa currently

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spends 8.3% of its GDP on public and private health care combined. Although this is above the World Health Organisation's recommendation of 5%, it should be taken into account that 4.1% of the 8.3% is spent on private health care, which only services 16.2% of the population. The remaining 83.8% of the population therefore has to make do with the public health care system, which is financed with the remaining 4.2%. Broken down into numbers, this means that 42 million individuals using public health care have the same amount of money available for medical care as the fortunate 8.2 million individuals making use of private health care (Amado *et al.* 2012).

When comparing health care spending in South Africa with other OECD countries, it is evident that the percentage of GDP spent on health care in South Africa in 2011 fell below the OECD average of 9.3% (OECD, 2013). This is illustrated in Figure 2.2.

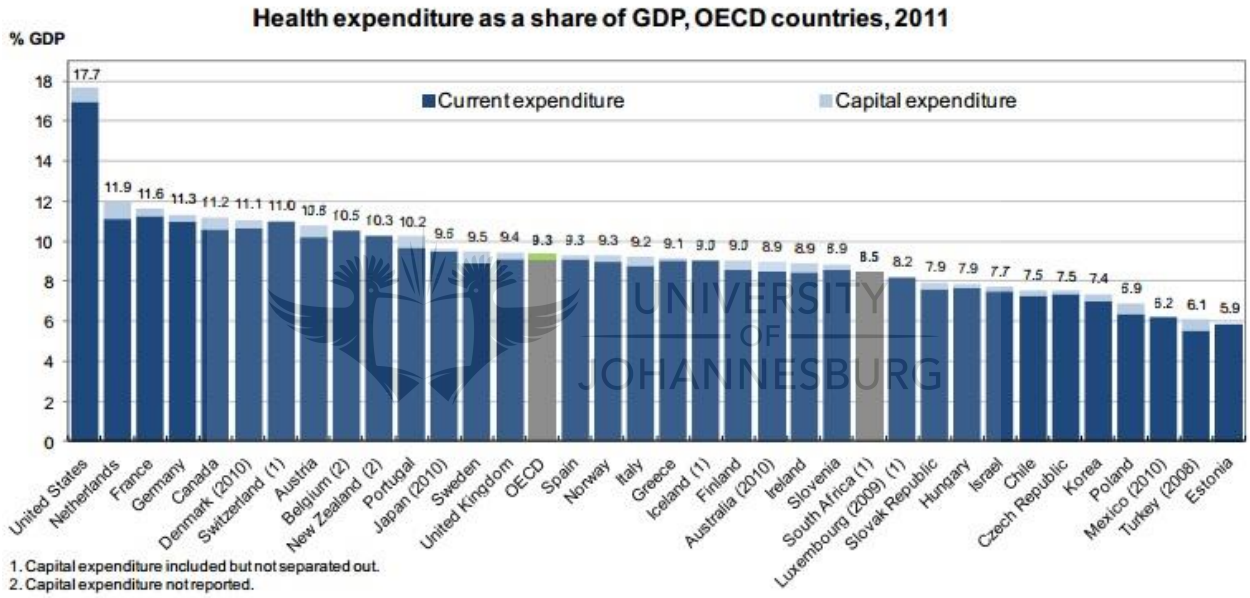

Figure 2.2: Health expenditure as % of GDP

Source: OECD Health Data (2013)

According to the OECD Health Data report of 2013, health spending tends to rise with income. This also leads to countries with a higher GDP per capita to spend more on health. As illustrated in Figure 2.3 below, this trend results in South Africa ranking below the OECD average in terms of health expenditure per capita, with spending of US $943 in 2011, compared to the OECD average of US $3 339 (OECD, 2013).

Based on this comparison, it is evident that South Africa is currently spending considerably less on a per capita basis than other OECD countries.

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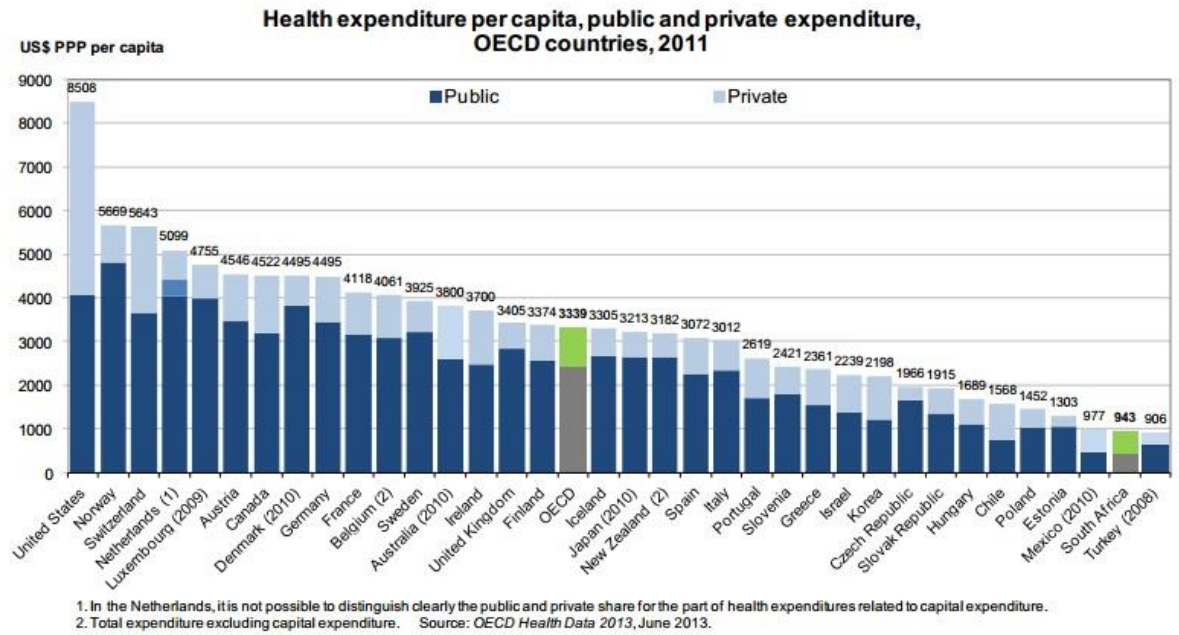

Figure 2.3: Health expenditure per capita in USD

Source: OECD (2013) Health Data

The OECD (2013) Health Data report states that in South Africa, 47.7% of health spending was funded from public sources in 2011. This is much lower than the OECD average of 72.2% in the same time period.

However, when comparing the South African health care spend not only with OECD countries, but with all countries globally, South Africa performs slightly better. The World Health Organisation released information in 2012 regarding total expenditure on health as a percentage of the GDP (World Health Organisation, 2012).

Figure 2.4 shows that South Africa's health care spend as a percentage of total GDP is comparable to countries like Australia, Brazil, Norway and Sweden. On paper, it would appear that South Africa is on par with the above-mentioned countries. To view this in perspective, however, it is important to note that this illustration is based on annual GDP. Countries like Australia had a GDP of US $1 560 billion, compared to the US $350 billion of South Africa (World Bank 2014a).

This would mean that although South Africa's health care expenditure as a percentage of GDP is in line with other developed countries, it cannot be seen as the final benchmark, as the South African GDP is much lower than in other developed nations.

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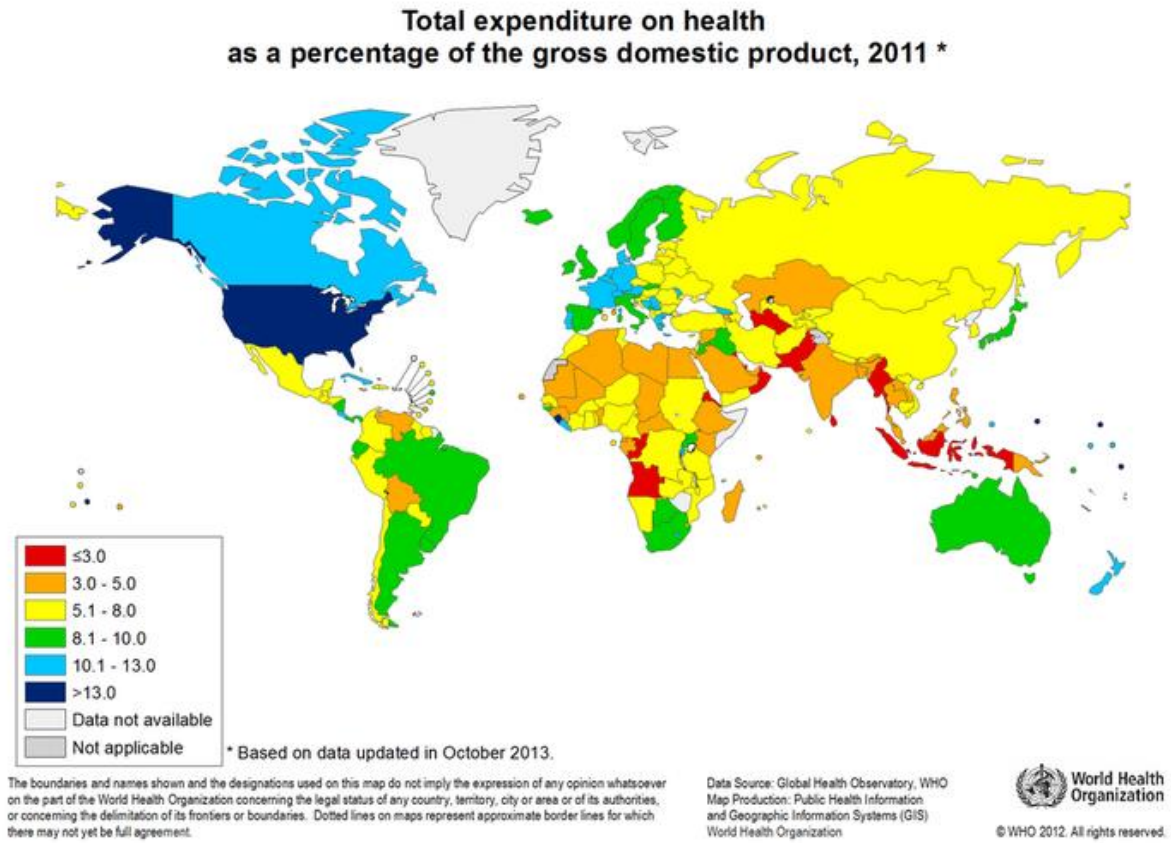

Figure 2.4 Health care expenditure as % of GDP

Source: World Health Organisation 2012

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It is therefore important to compare health care expenditure as a percentage of GDP with GDP per capita to take into account the size of the population of a country.

According to the World Bank (2014b), the South African GDP per capita was US $6 618 in 2013, compared to Australia's GDP per capita of US $67 468. It is thus clear that Australia's GDP per capita is ten times that of South Africa's. When comparing health care spending as a percentage of GDP per capita, it becomes evident that a country like Australia currently spends ten times the amount on health care per citizen than South Africa.

2.2.3 What will the South African National Health Insurance cost?

The Department of Health (2011a) Policy Paper states:

> "It is not possible to model with 100% accuracy the precise resource requirements of the future National Health Insurance, but the figures presented provide a good indication of the likely magnitude of resource requirements and more importantly, allow for the implications of key

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National Health Insurance design elements (e.g. different benefit packages) to be assessed."

The preliminary cost estimates provided in the Policy Paper are outlined in Table 2.1 below.

Year	Non-AIDS-related services	AIDS-related services	Additional services	Total direct healthcare costs	NHI operational costs	Total costs in delivering services	NHI implementation costs	Total costs modelled
2011	0	0	0	*0*	0	0	103,315,363	103,315,363
2012	57,773,124,913	17,166,207,505	42,270,916,229	117,210,248,647	586,051,243	117,796,299,890	7,562,523,092	125,358,822,983
2013	63,018,663,899	19,715,909,555	43,466,836,571	126,201,410,025	873,313,757	127,074,723,782	7,688,065,131	134,762,788,914
2014	68,743,700,878	21,986,952,564	44,663,128,851	135,393,782,293	1,196,881,035	136,590,663,329	7,817,527,358	144,408,190,686
2015	74,548,475,525	26,244,506,794	45,874,322,881	146,667,305,200	1,578,140,204	148,245,445,404	7,950,910,914	156,196,356,317
2016	80,827,911,456	28,728,750,718	47,094,626,628	156,651,288,802	1,986,338,342	158,637,627,144	8,088,221,201	166,725,848,345
2017	87,641,230,832	31,030,939,052	48,325,812,591	166,997,982,475	2,438,170,544	169,436,153,019	8,229,467,732	177,665,620,751
2018	95,052,680,344	33,149,581,757	49,568,979,121	177,771,241,221	2,936,780,905	180,708,022,126	8,374,663,993	189,082,686,119
2019	103,126,628,663	35,111,160,178	50,824,874,097	189,062,662,938	3,486,315,505	192,548,978,442	8,417,349,306	200,966,327,749
2020	111,940,398,283	36,941,489,310	52,094,075,790	200,975,963,382	4,091,870,614	205,067,833,997	8,568,371,192	213,636,205,189
2021	121,576,843,333	38,660,495,022	53,376,896,309	213,614,234,664	4,759,325,148	218,373,559,813	8,723,363,285	227,096,923,097
2022	127,854,878,098	40,285,667,400	53,611,943,556	221,752,489,054	5,366,410,235	227,118,899,289	8,882,352,922	236,001,252,211
2023	134,559,644,807	41,834,116,750	53,831,486,738	230,225,248,294	6,013,483,485	236,238,731,780	9,045,370,841	245,284,102,621
2024	141,730,835,738	43,303,832,918	54,036,013,619	239,070,682,276	6,703,541,931	245,774,224,207	9,212,451,095	254,986,675,302
2025	149,406,746,586	44,715,842,637	54,225,907,657	248,348,496,879	7,450,454,906	255,798,951,786	16,410,894	255,815,362,679

Table 2.1: Healthcare delivery and National Health Insurance implementation preliminary cost estimates
Source: Department of Health (2011a)

According to the Policy Paper, the NHI will require a start-up cost of R125 billion in the first year, which will increase to a real term of R255 billion in the fourteenth year if implemented over a fourteen-year period.

According to National Treasury (2014) the budget allocation for health care in South Africa amounted to R146 billion in the 2014/2015 fiscal year.

KPMG (2011) calculates that the proposed NHI in South Africa will cost on average R10.4 billion every year, over and above what is currently spent on public health care. This amounts to a total of R145 billion in real terms over the next fourteen years.

It is thus apparent that extra funding over and above the current spending levels of the Department of Health will be needed to finance the implementation of the NHI over the proposed fourteen-year period.

2.2.4 National Health Insurance Funding Options

In the 2012 Budget Speech (National Treasury, 2012), the Minister of Finance at the time, Pravin Gordhan, stated that there were a number of options under consideration.

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These options included an increase in the Value Added Tax (VAT) rate, a possible payroll tax on employers and a surcharge on the taxable income of individuals. The Minister mentioned that a combination of these funding alternatives was also a possibility.

In order to determine the viability of these three funding options, these alternatives are explored in detail below.

2.2.4.1 Increase in Value Added Tax (VAT)

According to Delfin (2004), Value Added Tax (VAT) was introduced in South Africa on 29 September 1991. The VAT system replaced GST (General Sales Tax) as an indirect tax system. It is levied in terms of the Value Added Tax Act 89 of 1991 and was initially imposed at 10% but was subsequently increased to 14% in 1993.

PWC (2012) state that governments worldwide have been seduced by the ability of VAT to generate large amounts of revenue at a very low cost when compared to direct taxes such as personal income tax. An increase in the VAT rate would therefore seem an easy answer to the funding predicament of the South African NHI.

According to National Treasury (2013), R813 billion was collected in taxes in the 2013 fiscal year, with 26.4% of General Tax Revenue derived from VAT.

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KPMG (2011) calculates that the extra cost of NHI could be funded by a 0.8% increase in the VAT rate. This would lead to a real term funding of the calculated R10.4 billion average extra costs over the fourteen-year implementation period.

The increase in the VAT rate in South Africa would therefore appear to be an easy way to increase tax revenue to fund health care.

The Netherlands Economic Institute (1998) however discusses the major social problem with VAT by explaining that VAT is seen as a regressive tax form. According to the Institute, VAT is seen as a regressive tax form because lower-income households would spend a larger proportion of their disposable income on VAT than higher-income households. Value Added Tax in South Africa is calculated at 14%, no matter what the level of household income. An increase in VAT would therefore have a much greater impact on the poor.

Parker (2012) agrees that if the VAT rate were to be increased, the less privileged and the poor would be most affected.

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This issue becomes an even greater concern when taking into account the effect of VAT on the unemployed. As mentioned above, according to Statistics South Africa (2014), South Africa currently has a 25.5% unemployment rate. This would mean that all unemployed individuals would be subject to an extra VAT expense without earning any income.

It is thus evident that South Africa would need to exercise caution if it were to use an increased VAT rate as a source of revenue required to fund the South African NHI.

2.2.4.2 Payroll Taxes

According to Seccombe (2012), South Africa is making use of an Unemployment Insurance Fund (UIF) towards the social welfare of all working employees. This UIF fund is sustained through a 1% contribution from employees and employers, resulting in a 2% contribution of employee remuneration.

The South African Revenue Service states that the UIF fund raises approximately R12 184 billion each year (National Treasury, 2013). This is more than the extra amount of R10.4 billion that will required on a yearly basis up until 2025 to implement NHI, as estimated by KPMG (2011).

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This explains why introducing an extra payroll tax in South Africa appears as an attractive alternative of raising funding, as revenue can be collected through the existing tax system.

Broomberg (2009), however, is of the opinion that an increase in existing tax rates to fund the proposed health insurance scheme would have serious repercussions on the economy. Furthermore, he argues that in light of the current economic environment, the suggested increase of 2% to 5% that would be shared by employers and employees would have a significant negative impact on job creation and the employment environment.

Further, McIntyre (2010) states that it is evident that a substantial increase in public funding would be required to provide universal cover for all South Africans. In her opinion, the health care budget allocation should gradually increase to 15% of the total budget which would, however, place enormous strain on the budgetary claims of other sectors. Therefore, other forms of revenue would need to be found in order to prevent 'crowding out' the claims of other sectors. Ataguba and McIntyre (2009) further found that should government health care expenditure originate from South African general tax revenue, serious consideration should be given to a mandatory, dedicated income

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tax deduction that would be shared by the employer and the employee. McIntyre comes to the conclusion that although this form of funding is most probably the most viable, it would nonetheless have a serious impact on the tax burden of low-income earners. These individuals would battle to absorb an additional dedicated expense from their wages and therefore consideration should be given to a progressive tax deduction, rather than a proportional one. This would at least ensure that high-income earners would subsidise the contributions of low-income earners, which would relieve some of the burden. The downside would be that the high-income earners would once again end up bearing the lion's share of the burden.

2.2.4.3 Tax surcharges

When exploring the theoretical meaning of the term 'sur-tax', the Macmillan English Dictionary for advanced learners (2006:1448) defines the term as follows:

> "An additional tax on something that is already taxed, especially high income."

Another definition is found in the Oxford Advanced Learner's Dictionary of Current English (2006:1491) which states that 'sur-tax' is defined as:

> "A tax charged at a higher rate than the normal rate on income above a particular level."

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According to Deloitte (2012), a tax surcharge on existing income would lead to higher-income South African taxpayers paying an additional tax on their existing taxable income in order to fund the extra health care expenditure required by the proposed National Health Insurance scheme.

Deloitte (2012) further found that in 2012, 45% of all SARS revenue was generated from only 25% of South African tax payers, all of whom fall within the "middle class" (R260 000 to R1 000 000) tax bracket. Furthermore the 2% wealthiest South African individuals are responsible for 25% of South African tax revenue. It is therefore important to note that the number of high-income earners in South Africa and their level of income will be the main factors when considering a tax surcharge as a source of extra revenue to fund the NHI.

2.2.5 Planning and implementation

Broomberg (2009) has made a very valuable contribution to the public debate on the proposed NHI in South Africa. As the CEO of Discovery Health in South Africa, Mr

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Broomberg believes that any health care reform should be firmly based on the following principles:

1. The proposed health care reform should be based on transparent and vigorous public debate and hard evidence;
2. The proposed health care reform should uplift public health care standards;
3. The proposed health care reform should be rooted in South Africa's economic realities; and
4. The existing private health care system should be seen as part of the solution, not as part of the problem.

Broomberg (2009) maintains that the Department of Health has not explored whether the difficult existing economic climate would allow a national health insurance system to provide an all-inclusive package of health benefits for all South African citizens.

It is therefore evident that a number of important issues regarding the planning and implementation of an NHI remain unanswered by the South African government, with stakeholders awaiting the release of a White Paper on the subject since 2011.

2.2.6 Private health care partner

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Partnerships between public and private sectors to fulfil specific public functions have been on the increase at every level of government. These public-private partnerships represent an effort to bring about competitive market discipline in the public sector whilst sharing financial risks and responsibility (Linder & Rosenau, 2000).

Dr Richard Friedland, CEO of Netcare South Africa, has addressed the Hospital Association of South Africa and stated that there is no reason why private hospitals could not provide services to public health sector patients through innovative public-private partnerships (Hospital Association of South Africa, 2012).

Of the approximately R70 billion spent by medical scheme members on health care in South Africa on a yearly basis, R57 billion is money spent purely by private individuals. The R13 billion balance is provided by treasury as a tax subsidy, recognising that those who fund their own public health care are not a burden on the public sector (Broomberg, 2009).

These statistics support the fact that the private health sector in South Africa is currently playing a substantial role in providing health care services, even though it is

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only to 16.2% of the population, as mentioned by the Council for Medical Schemes (2012).

Dr Richard Friedman further emphasised that a vital component of South Africa's medical experts and professionals is currently employed in the private health care sector. Friedman stated that one of the most critical factors in a public-private partnership is to ensure long-term sustainability by providing ongoing training and to transfer skills to public health care staff (Hospital Association of South Africa, 2012).

One of the biggest criticisms against the private health sector in South Africa, however, is the problem of uncontrolled commercialism. The World Health Report (2008), cites unregulated commercialism as one of the three trends that undermine a health system's response. It explains that in many low- and middle-income countries around the world, the under-resourcing of public health services has accelerated the development of commercialised health care. The report defines commercialised health care as the unregulated fee-for-service sale of health care by both public and private health care providers, as it often cuts across the public-private divide.

The World Health Report further indicates that this has become an increasing problem due to governments introducing commercialised cost-recovery systems which have shifted the cost of services from government funding to the end user in an attempt to compensate for the chronic under-funding of the public health sector World Health Report (2008).

In his keynote address at the Sixth Annual Conference on Competition Law, Economics and Policy, the South African Minister of Health, Dr Aaron Motsoaledi, welcomed the Competition Commission's decision to initiate a market enquiry into the private health sector to investigate this concern in the South African health care market. At the conference the Minister argued that in comparison with the other BRICS countries, only Brazil is spending more on health care per capita than South Africa, yet South Africa produces the worst health care results of all the BRICS countries (Competition News, 2012).

It can therefore be concluded that South Africa will have to ensure that the relatively large amount of GDP being spent on health care is utilised as efficiently as possible whilst ensuring that health care does not become an unaffordable commodity which can be bought and sold on a fee-for-service basis without regulation or consumer protection.

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2.3 CONCLUSION

This chapter thus concludes that the current South African health care system is in dire need of urgent re-engineering. The existing health system has two extremes, with a well-resourced, efficient but expensive private sector on the one hand versus the under-funded and mismanaged public sector on the other hand.

The great income disparity in South Africa has escalated this problem to its current levels and has resulted in inequitable access to health care services for South African citizens.

The South African government has an ethical obligation in terms of Section 27 of the South African Constitution (1996) to improve the existing system to provide all citizens with access to health care resources and services.

That said, it is imperative to take into account the current economic environment and the availability of funding in order to plan and implement the most viable health care solution in South Africa. The current unemployment rate and the flagging economy, together with rising health care costs, make it very hard to raise additional health care funding through different forms of taxation for the implementation of the proposed National Health Insurance system.

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The possible increase in the rate at which VAT is levied in South Africa could contribute to a major part of the funding for the proposed National Health Insurance scheme. However, because of the significant impact that an increase in the VAT rate would have on the less privileged and the poor, this method of funding will need to be given very careful consideration.

It seems that funding the National Health Insurance scheme through a dedicated payroll tax or a tax surcharge is a more viable option as it would place a lesser burden on the unemployed and the poor, although this would still have to be thoroughly investigated to determine viability.

The following chapters will discuss different health care models used in the world, and will analyse the different systems currently being used by first and third world countries to determine the best proven funding mechanisms that South Africa should consider.

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CHAPTER 3

NATIONAL HEALTH CARE MODELS

3.1 BACKGROUND

According to Reid (2009), there are approximately 200 countries around the world which devise their own set of arrangements for meeting the three basic goals of a health care system, namely:

- Keeping people healthy;
- Treating the sick; and
- Protecting families against financial ruin because of large medical bills.

Saha (2011) is of the opinion that each nation's health care system is a reflection of its:

- History;
- Politics;
- Economy; and
- National values.

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Although these four elements of the different health care systems around the world vary to some degree, they all share common principles. As a result, all countries around the globe make use of one of four international health care models, or a combination thereof.

These models include the:

1. Bismarck model;
2. Beveridge model;
3. National Health Insurance model (NHI); and
4. Out-of-pocket model (OOP).

This chapter will analyse the four health care models used by nations to form their individual health care approaches.

3.2 BISMARCK MODEL

Schnackenberg (2011) states that the Bismarck model was the first health system, founded by the Prussian Chancellor, Otto von Bismarck, in 1883. Bismarck health care models are also commonly referred to as social health insurance.

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Reid (2009) explains that this model uses a legally mandatory insurance system that is financed jointly by employers and employees through payroll deductions.

Kutzin (2011) explains that this model was not initially developed to supply universal cover for all German citizens, but rather as a compulsory funding scheme that ensured all employees had access to medical care. It is thus clear that this model was not intended to provide medical care for the nation as a whole, but only for those residents who were employed.

This system, which has since been through a major reform, now ensures more comprehensive cover for those European communities which have adopted it (Du Toit, n.d.).

Schnackenberg (2011) further explains that this system is a multi-payer system based on the following three parties:

1. **Population:** All employees are legally bound to contribute to the system. As this system has evolved over time, it now makes provision for unemployed citizens who do not contribute, for example, children and pensioners.
2. **Providers:** Services are provided by both private and state-owned providers.
3. **Contribution Collectors:** These are third-party legal entities responsible for collecting revenue from the insurance scheme. These collectors work independently of health care providers.

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The Bismarck model is discussed in detail by Gottret and Schieber (2006) in their book *Health Finance Revisited: A Practitioner's Guide.* They indicate that there are advantages and disadvantages to every model and summarise the advantages of the Bismarck model as follows:

- Increased resources for the health care system as the entire working population contributes to the insurance funds.
- Decreased dependence on state budget negotiations as funding is supplied by insurance companies.
- High redistributive dimension as high-income participants subsidise low-income participants.
- Strong public support for the insurance funds as the health care system ensures cover through an insurance-based programme.

Gottret and Schieber (2006) summarise the disadvantages of the Bismarck model as follows:

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- Possible exclusion of the poor as the unemployed might be excluded from certain health care benefits.
- Payroll contributions can have a negative impact on the economy.
- Difficult and expensive management of these insurance funds, which need to provide for large numbers of people and involve many different players.
- Heavy subsidisation of social health insurance can generate an excess demand for health services, which could in turn lead to escalating costs of such services.
- Poor cover for chronic diseases and preventive care as this requires the intervention of several professionals and strong co-ordination among them.

Gottret and Schieber (2006) further discuss the feasibility of social health insurance schemes in developing countries. The most important factors to consider are:

1. Level of Income

   Social health insurance models tend to flourish in countries that have strong economic growth as it is easy to absorb new contributions in a prosperous economy.

2. Size of the informal sector

   A large informal sector means the payroll base for contributions is small, which is problematic in raising resources for health care.

3. Distribution of the population

   Urbanisation and increased population densities in cities make it easier to register members and collect contributions. Countries where the rural population is preponderant have seen much slower implementation of social health insurance models.

4. Administrative capacity

   Social health insurance systems normally rely quite heavily on skilled administrative staff to ensure that they are run effectively.

5. Good quality health care infrastructure

   The quality of health infrastructure is of the utmost importance in a successful health insurance system. Even the best designed social health insurance system remains an empty shell if the country does not have sufficient infrastructure to provide the necessary health care services included in the benefits package.

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Countries that have implemented the Bismarck model seem to include mostly developed countries, namely Germany, Belgium, Netherlands, Japan and Switzerland.

3.3 BEVERIDGE MODEL

The Beveridge model is named after William Beveridge, the pioneering social reformer who designed Britain's National Health Service. Systems based on this model are known for their low cost per capita, because the government, as the sole funder, can control what services and procedures doctors can provide and what they are allowed to charge. Beveridgean models are also referred to as state-funded health care systems as financing is provided solely by the state (Reid, 2009).

Schnackenberg (2011) characterised the Beveridge system as a tax-based system that includes the entire population. Financing is supplied solely by the government through general taxes and provides services such as prevention, diagnosis and treatment for the whole population free of charge.

A Beverdigean system relies on a sole payer, which ensures that no citizen will ever be burdened with a medical bill. Medical services are a public service to the entire community and are provided by the government (Saha, 2011).

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It has been noted that the Beveridge model is normally introduced in high-income first world countries where there is a clear shift from health cover as a right of labour, to "health as a human right" (Kutzin, 2011).

Gottret and Schieber (2006) explain that countries that introduce Beveridgean systems are basically state-funded health care systems. They further conclude that state-funded systems are suitable for most countries that are administratively strong and have the economic capacity to raise taxes.

Gottret and Schieber (2006) list the advantages of the Beveridge model as the following:

- The entire population is covered for medical care and health services.
- Taxes are collected from a very broad revenue base.
- Governance and control of health care is easier to manage as it lies with one authority.

There are also a number of disadvantages to a Beveridgean system which can be summarised as follows:

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- Funding can be unstable as it has to compete with other state departments for its share of the annual budget.
- The rich benefit disproportionately as they have better access to state-funded health care.
- Health care delivery can be inefficient as it is impossible to access alternative providers.
- Sensitivity to political pressure as health care can be used in political struggles.

Gottret and Schieber (2006) highlight that the feasibility of state-funded health care systems in developing countries must first be considered before implementation can occur. The most important factors to consider are:

1. Revenue raising capacity

   A country's ability to raise revenue depends primarily on its economic situation. Countries with slow economic growth will face greater challenges in raising sufficient revenue to cover medical expenditure for the nation as a whole.

2. Quality of governance

   A strong tax administration is crucial in facilitating the collection of revenue. Governance is also very important in determining the effectiveness of health spending.

3. Ability to target the poor while maintaining the universality of the system

   One of the most challenging aspects of introducing a health care approach is ensuring that the entire population of a country will equally benefit from the model. In developing countries income disparity is normally much larger than in developed countries. Countries therefore need to be cautious when implementing a health care model to ensure that both the rich and the poor will benefit equally.

Countries that currently follow a Beveridgean approach include Great Britain, Spain, New Zealand, Scandinavia and Cuba.

3.4 NATIONAL HEALTH INSURANCE MODEL

Reid (2009) claims that a National Health Insurance model has elements of both the Beveridge and the Bismarck models. Payments are made by a single-payer, government-run insurance programme that uses private sector providers to deliver services. These systems tend to be cheaper and have a smaller administrative burden.

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Reid (2009) further states that government has considerable market power to negotiate lower prices as it is the sole funder of the system.

According to Lee, Chun, Lee and Seo (2008), a National Health Insurance system is characterised by private sector providers while the government centrally administers health care financing covering the entire population. All citizens are obliged to contribute to this government-run insurance programme.

Saha (2011) elaborates on this statement by stipulating that the government collects the funds to provide these health care benefits through tax contributions from citizens. Such government-run insurance programmes are thus funded predominantly through tax payments that are administered by the fiscus.

Dahms (2013) summarised the advantages of a National Health Insurance system as:

- All residents, including low-income groups and entry level workers, enjoy health care benefits.
- Government funding or donor contributions help to subsidise premiums for the intended population.
- It works well with other financing initiatives.
- Administration is easier to manage as payments issue from a single entity.

Dahms (2013) outlines the challenges of National Health Insurance systems:

- The poor need to be funded and subsidised.
- Financial protection and the benefit packages are limited as the funding comes from a single entity.
- Because these systems are administered by government, benefits are limited as the governments risk pool is small.

Countries currently employing a National Health Insurance approach include Canada, Taiwan and South Korea.

3.5 OUT-OF-POCKET MODEL

Reid (2009) highlights the fact that only a small portion of nations across the globe actually have established health care systems. Most countries are too poor and disorganised to provide any form of mass medical care. In such systems, it unfortunately comes down to the fact that the rich get medical care because they can afford it while the poor stay sick or die.

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Saha (2011) further describes nations employing the Out-Of-Pocket model as 'No-System' countries. Saha also emphasises that in these countries, all medical expenses are covered by patients themselves.

According to OECD (2011), financial protection through private or public health insurance substantially reduces the costs that households pay for medical care out of their own pockets. Countries with Out-Of-Pocket models thus place a big burden on their population to ensure medical care is received when necessary, as no form of assistance is provided in funding health care.

Dahms (2013) state that the advantages of an Out-Of-Pocket model are:

- High-earning individuals can afford medical care.
- Wealthy members of the population can choose which providers they prefer.

Dahms (2013) further describes the challenges of such a model as:

- No universal cover for citizens.
- No form of assistance provided by government.

There are numerous countries around the world which have no organised health care system and which therefore rely solely on the Out-Of-Pocket model. Some of these countries include Burkina Faso, Ethiopia and rural India.

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3.6 CONCLUSION

It is clear that there are a number of health care models and alternatives which need to be considered before a final decision can be made on the exact health care approach that a country chooses to follow.

Each of these approaches has its own set of advantages and disadvantages which need to be thoroughly investigated to ensure that the best possible system is chosen for each country's specific set of variables. None of the models is good or bad in itself; the success of any system in a given country depends on a series of preconditions and the government's ability to influence them.

A summary of the most important characteristics of the different health care models discussed in this chapter is presented in table 3.1 below.

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Table 3.1: Summary of health care models

Model	Private	Public	Mixed Private and Public	Single / Multi-Payer
Bismarck			X	Multi-Payer
Beveridge		X		Single Payer
National Health Insurance	X			Single Payer
Out-Of-Pocket	X			Single Payer

In South Africa, the main concerns that need to be taken into account when committing to a health care model is firstly the high unemployment rate and secondly the diversity of the population, particularly when considering the enormous levels of income disparity. South Africa has a very diverse population - there is a large component of low-income families on the one hand, and a broad spectrum of families in the middle- to high-income bracket on the other. Countries like the USA have combined various aspects of different health care models in order to shape their health care system. The conclusion of this study, with recommendations for a South African approach to health care, will be discussed in greater detail in Chapter 6.

Chapter 4 will now look into the approaches followed by selected first world, developed countries, whilst chapter 5 will follow with a similar analysis of health care models adopted by third world, developing countries.

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CHAPTER 4

FUNDING HEALTH CARE IN FIRST WORLD COUNTRIES

4.1 INTRODUCTION

In order to arrive at a workable solution regarding the funding of health care in South Africa, it is important to first consider the lessons learnt from similar initiatives in a number of other countries around the world. South Africa has the advantage of learning from the experience of others and can therefore avoid the pitfalls associated with health care financing. Dutton (2007) explains that the success of health care systems is based on cost, efficiency and access. South Africa has the opportunity to assess these three criteria, as implemented by other countries around the world before deciding on a final approach for its own national health insurance system.

This chapter is devoted to first world countries and their health care funding models, and is followed by Chapter 5, which explores health care funding approaches in third world or developing countries. The analyses conducted in both chapters will provide a global perspective on health care financing and delivery, which can then be compared to the proposed South African approach. Based on these comparative findings, recommendations will be made in Chapter 6 on important issues South Africa should consider when finalising its approach.

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In order to understand the context of health care financing, it is important to have a better understanding of what is meant by the term 'first world'. The term is defined by the Merriam-Webster online dictionary as:

> *"The highly developed industrialised nations, often considered the westernised countries of the world."*

It is further explained by the Merriam-Webster online dictionary as:

> *"The countries of the world that have many industries and relatively few poor people: the rich nations of the world."*

The approach adopted in this chapter therefore defines first world countries as those with high income levels, and with reasonable, accessible and efficient health care services. The three first world countries that will be investigated in this chapter are France, the United States of America and the United Kingdom.

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4.2 FRANCE

Fourteen years ago, the World Health Organisation released the World Health Report 2000 wherein health care systems around the world were ranked according to five factors, namely *quality*, *access*, *efficiency*, *equity* and *fairness of financial contribution*. France was ranked number one and has since been subject to much scrutiny (Taylor & Blackstone, 2012).

Although these results have since been widely criticised, indicators of overall satisfaction and health status support the finding that the French health system is indeed impressive and merits closer inspection by anyone interested in health care reform (Rodwin, 2003).

It is for this reason that France has been included as one of the first world health systems that will be investigated in this chapter.

4.2.1 Background to French Health Care

Shapiro (2008) explains that the French National Health Insurance system called *sécurité-sociale* has achieved universal cover through a Bismarck system approach provided through a public-private provider mix. This means that medical services are provided to the 66 million French citizens by both public and private medical providers through a multi-payer system.

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Dutton (2007) states that the French National Health system covers services ranging from hospital care, out-patient services, prescription drugs, nursing homes as well as dental and vision care.

According to Rodwin (2003), the French National Health system evolved in stages, in response to demands for extended cover.

Rodwin (2003) summarised the evolution of the National Health Insurance system in the following chronological order:

1928 System is established and covers low-income salaried workers, thus effectively only covering the poor.

1945 System is broadened to include all industrial and commercial workers and their families, irrespective of income levels.

1961 System is expanded to include farmers and agricultural workers.

1966 System is further expanded to provide cover for independent professionals.

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1974 The French Constitution proclaims that the National Health Insurance scheme should be universal and cover the entire population.

2000 Comprehensive cover is obtained for the entire French population, based on residence in France.

It is therefore clear that the French health care system did not obtain its position and status as one of the leading health care systems in the world overnight. It was a long process, perfected and improved over a period of more than seventy years.

4.2.2 Funding of the French NHI

Shapiro (2008) states that besides the USA, France has the second most expensive health care system in the world. According to the World Bank (2013a; 2013b; 2014b), France spent 11.7% of its US $2 734 billion GDP on health care in 2012, which amounted to an average of US $4 968 per capita. France currently has a 10.2% unemployment rate which contributes to their large pool of NHI contributors OECD Stat Extract (2014).

In France, the national insurance programme is funded mostly by payroll and income taxes. French NHI funds finance 76.5% of medical expenditure, supplemented by approximately 12.4% private insurance and lastly, by out-of-pocket expenditure representing 11.1% (Rodwin, 2003).

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The French NHI forms an integral part of France's social security system and funding is provided by several NHI funds consisting of a main national health insurance fund as well as fourteen smaller insurance funds that provide for specific occupations and their dependants. All NHI funds in France are regulated by private organisations which are overseen by the government ministry responsible for social security (Rodwin, 2003).

4.2.3 Who is covered?

According to the Commonwealth Fund (2013), cover in France is universal. All residents are entitled to publicly financed health care through statutory health insurance from non-competitive social health insurance funds. Eligibility for medical care is based either on employment, or as a benefit to formerly employed people, students and retired citizens. The entire French population is thus covered and is entitled to free medical care.

4.2.4 Advantages and disadvantages of the French health care system

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Rodwin (2003) summarises the advantages and disadvantages of the French health care system in The American Journal of Public Health as follows:

Advantages

- The French system delivers high levels of service with increased consumer satisfaction.
- There are a great number of health delivery options which allows consumers to choose where and how they would like to be treated.
- The public perception of the French National Health Service is relatively good.
- There is a low level of micromanagement imposed on health care professionals by the state and the department of health.
- France has a lower level of health expenditure as a share of its GDP when compared to countries like the United States of America.

Disadvantages

- Medical services tend to be located in densely populated geographical areas which means the rural population struggles to access health care facilities.
- A perception has recently emerged of uneven quality in the distribution of health care services between different health care centres.
- France has imposed strong price control policies on the entire health sector which is not always welcomed by health care practitioners.

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4.2.5 Lessons to be learnt from the French NHI

1. It is possible to achieve universal coverage without a single-payer government system.
2. It is possible to achieve universal coverage without a 'big bang' reform, as the French have accomplished universal coverage in incremental stages.
3. Universal coverage can be achieved without excluding private insurers.
4. It is possible to implement a health care system that carries no stigma and is positively perceived by the public.
5. Health care costs must be managed through regular negotiations with the various parties involved in influencing pricing (Rodwin, 2003).

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4.3 THE UNITED STATES OF AMERICA

According to Rice, Rosenau, Unruh and Barnes (2013), the United States of America has the largest economy and one of the highest incomes per capita in the world. It is therefore important to consider the American approach to health care when assessing high-income countries. Because of this reason the United States of America is one of the first world countries that is supposed to set the tone for health care provision around the world. The abovementioned facts have led to the inclusion of the United States as one of the first world countries being analysed in this chapter of health care systems around the world.

4.3.1 Background to United States health care

For decades the United States has been spending more and more on health care without, however, achieving universal coverage for all of its 314 million citizens. Government funding increased from 31.1% in 1980 to 42.3% in 2011 and the United States devotes far more money to health care per capita than any other country in the world yet it has not been able to achieve universal coverage (Moses, Matheson, Dorsey, George, Sadoff & Yoshimura, 2013).

This is a growing concern for the United States government which is constantly attempting to address this problem. One measure to address this problem was the adoption of the Patient Protection and Affordable Care Act in 2010 (Rice *et al.* 2013).

The Patient Protection and Affordable Care Act, unofficially known as ObamaCare, is the much-debated and criticised legislation which was approved in 2010 and is currently being deployed in the United States. ObamaCare is the largest overhaul of the United States healthcare system since the 1960s and has the simple aim of extending health insurance coverage to the estimated 15% of the United States population which currently does not have any form of medical insurance (BBC News, 2014).

Despite their low unemployment rate of 6,3%, Rice *et al.* (2013) is of the opinion that the American health care system can be thought of as multiple systems that operate independently of one another, and at times, in collaboration with each other. The United States health care system is not primarily based on one of the four health care models discussed in chapter 3, but contains components of all four the models.

Up until 2010, the United States health care system was mainly made up of the following providers and insurers:

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- **Medicare**

Medicare is an insurance programme run by the American government and provides cover for American senior citizens over the age of 65, as well as some disabled individuals. People over the age of 65 are covered regardless of their income, but are required to make out-of-pocket co-payments when treated. Medicare is a single-payer programme administered by government (Baribault & Cloyd, n.d. & Chua, 2006).

- **Medicaid**

Medicaid is a financial assistance programme for low-income citizens. Medicaid membership is based on physical need and social welfare. Medical bills are paid for and funded from federal and state tax funds, making it a multi-payer system. It serves low-income people of all ages. Medicaid is administered by the different states (Baribault & Cloyd, n.d. & Chua, 2006).

- **Private Insurers**

Currently, 54% of United States citizens receive their health care coverage from private health insurance. Most of these privately insured individuals obtain their coverage through an employer as part of their employment package (Rice *et al.,* 2013).

4.3.2 Funding of the United States health system

According to the World Bank, the United States of America spent 17.9% of its US $16 244 billion Gross Domestic Product on health care in 2012. This would reflect the amount that was spent on both public and private health expenditure. The Centre for Disease Control states that the USA spent US $2.7 billion on health care in 2012. This equates to an average per capita amount of US $8 680 (World Bank, 2013a; 2013b; 2014b).

According to Rice *et al.* (2013) American health expenditure is funded as follows:

- 48% of funding comes from public sources, thus it is funded by government.
- 40% of funding comes from third-party insurers.
- 12% of funding is paid out-of-pocket by individuals.

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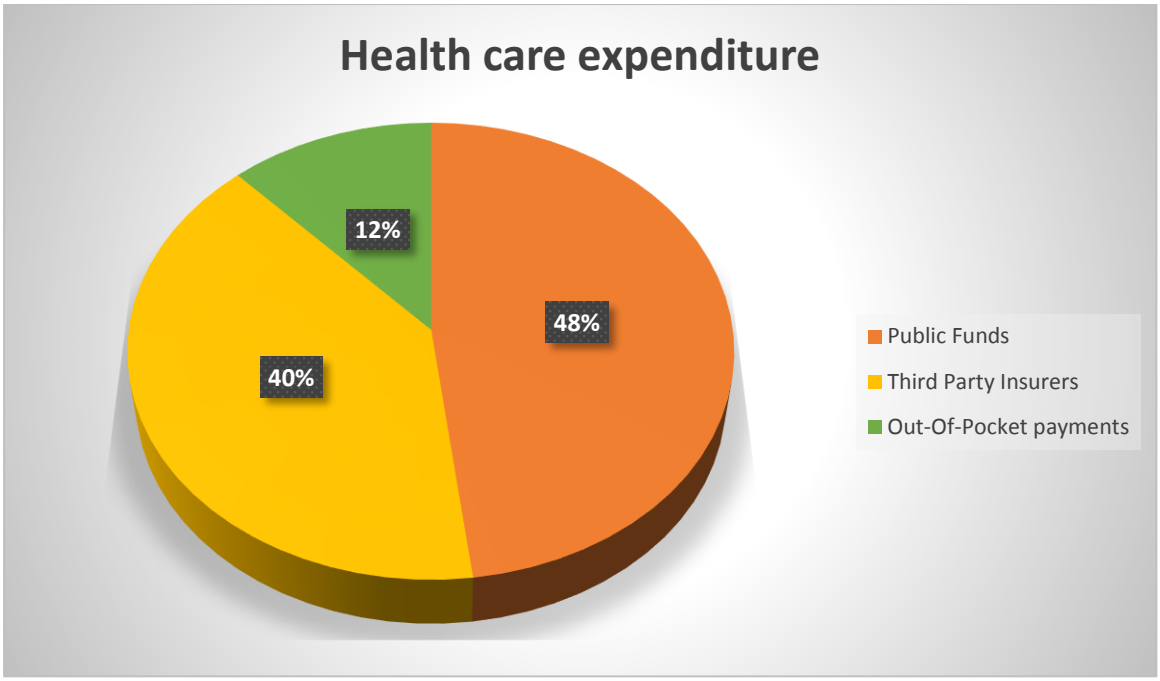

Figure 4.1: Health care funding in the USA

Source: Adapted from Health Systems in Transition (2013)

Chua (2006) mentions that the dominance of the private health care element in the United States over the public element is unique as this phenomenon is not as evident in any other country in the world.

Since 2010 the Patient Protection and Affordable Care Act, or ObamaCare, is being implemented in the United States in an attempt to broaden health coverage and to control costs. ObamaCare is controversial because of its mandate to ensure that every individual is being legally forced to either purchase health insurance or pay a penalty. Companies with more than fifty employees will be forced to offer health insurance as a benefit to their employees. Individuals who cannot afford health insurance will qualify for discounted rates. Insurance companies will not be able to turn down people because of pre-existing conditions and all individuals will thus be eligible for some sort of health insurance (Nather, n.d.).

4.3.3 Who is covered?

As mentioned by Chua (2006), private health insurance plays a significant role in the United States.

The Kaiser Family Foundation (n.d.) analysed the current coverage statistics in America as follows:

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Fifty-four per cent of the population is covered by private health insurance through employment-based programmes. Thirty-one per cent of the population is covered by public sources of health financing, mainly Medicare and Medicaid. Lastly, 15% of the American population does not have any form of health insurance and is not covered in case of a medical emergency. ObamaCare is aiming to supply these uninsured individuals with health coverage that they previously could not afford.

4.3.4 Advantages and disadvantages of the United States health system

According to Rice *et al.* (2013), the advantages of the US health care system can be summarised as follows:

- The United States has a large and well-trained health workforce.
- The United States has access to a wide range of high-quality medical technology and state-of-the-art facilities.
- The United States has a strong health research programme that conducts ground-breaking medical research.
- The United States achieves among the best medical outcomes in the world.

Squires (2012) states that the main disadvantage of the US health system by far is the fact that health care costs in America have spiralled out of control. Table 4.1 below demonstrates that the US average hospital spending per discharge in 2009 was almost triple that of the OECD median and thus the highest in the world.

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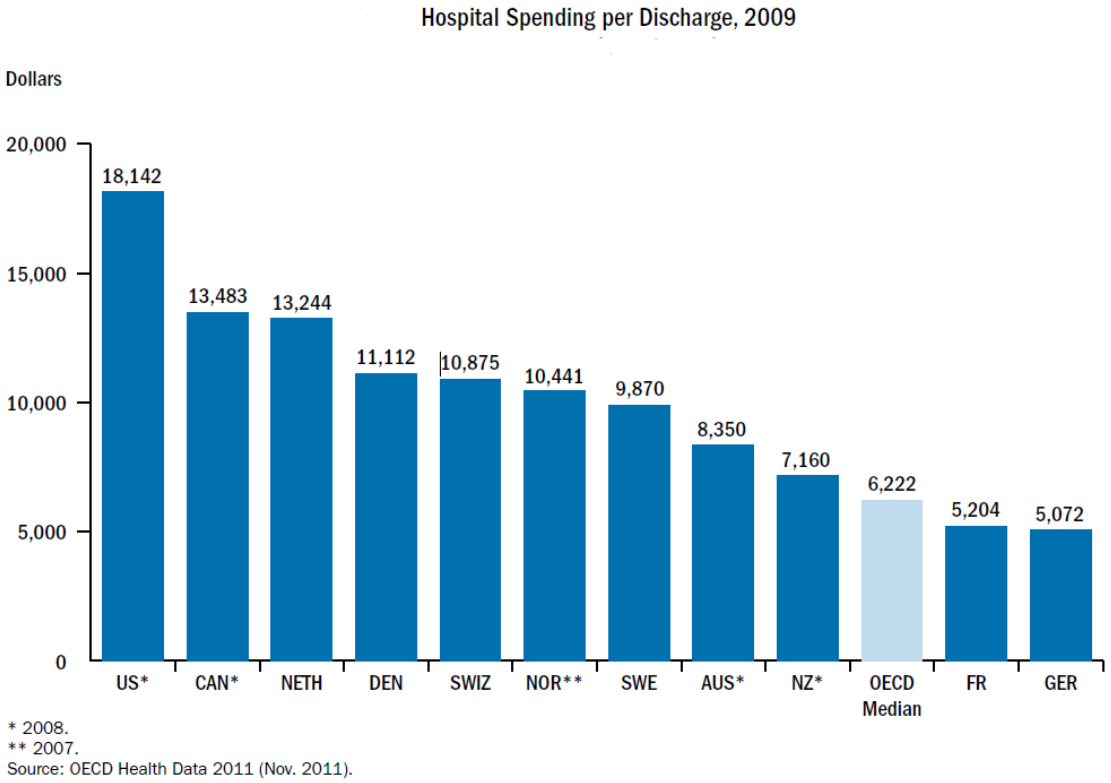

Table 4.1: Hospital spending per discharge

Source: OECD Health Data 2011

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Rice *et al.* (2013) states that another distinct disadvantage is the low level of government involvement. Lack of guidance and cost regulation by the federal government has led to uncontrolled commercialism.

Further disadvantages of the current United States health care system are summarised by Rice *et al.* (2013) as follows:

- Incomplete coverage as a large proportion of the US population does not have medical coverage.
- Poor access to medical care facilities.
- Health care costs have spiralled out of control because of uncontrolled commercialism.
- Poor measures on many goal objectives result in lacking health care provision.
- Unequal distribution of resources and outcomes across the country is resulting in disadvantages and is problematic for many rural Americans.

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4.3.5 Lessons to be learnt from the United States health system

According to Light (2003), the two most important lessons that can be learnt from the United States are:

1. Health care spending should be controlled and regulated; and
2. Costs must be kept down through a co-ordinated financing system.

4.4 THE UNITED KINGDOM

The United Kingdom has the largest and oldest single-payer health care system in the world, dating back to 1948. The British National Health Service (NHS) is one of the most widely studied models of universal health programmes. It is therefore imperative to explore the British NHS system as part of this chapter on health care provision in first world countries in an effort to learn from the British experience. (Cicconi & Strug, 1999)

4.4.1 Background to health care in the United Kingdom

The National Health Service (NHS) in the United Kingdom was established on 5 July 1948 with the aim of providing a broad range of health services to all United Kingdom citizens (Davies, 2011)

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Although each of the countries making up the United Kingdom has chosen to structure its NHS differently, a common theme of NHS funding is the allocation of a significant portion of the total NHS budget to local organisations like primary care trusts and health boards, which are ultimately responsible for meeting local needs (Harker, 2012).

Harker (2012) explains that the NHS ultimately places the responsibility for the provision of health services with the secretary of state for health in England, the minister for health and community care for Scotland, the minister of health and social services for Wales and the minister of health, social services and public safety in Ireland.

Funds are allocated using a needs-based formula founded on the principle that it is necessary to accomplish equal access to health care services for people at equal risk across the country (Harker, 2012).

The NHS in the United Kingdom has, however, been subject to increasing criticism over the past decades. Its single payer funding approach is now almost unique, as

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virtually all other countries have moved towards mixed systems in order to combine equity with commercial incentives (Adam Smith Institute, n.d.).

Davies (2011) describes the NHS as "…health care that remains a fifties-style nationalised industry – a cartel whose members are committed to maintaining, in all essentials, the basic reward structure they negotiated in 1948, and which has served them well for the last sixty years."

In 2003 Dr Donald W Light accurately summarised the United Kingdom NHS as no longer being sustainable and a quaint utopia that is not affordable anymore (Light, 2003).

This growing concern forced Tony Blair and his cabinet, and more specifically the Minister of Health, Alan Milburn, to admit in the early 2000s that the NHS had for years been starved of funds. They then embarked on a programme of raising national health insurance tax to fund the largest increases in the history of the NHS (Light, 2013).

4.4.2 Funding of the health system in the United Kingdom

The majority of NHS funding is ultimately derived from central United Kingdom taxation whilst a small portion is raised through patient charges known as co-payments (Adam Smith Institute, n.d.).

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According to Harker (2012), one of the most prominent issues in health care funding over the last fifty years has been growth in health expenditure by far exceeding the rise in both GDP and total expenditure. This means that the cost of health care in the United Kingdom has increased at a higher rate than increases in funding and budget allocations.

The Office for National Statistics (ONS) (2014) in the United Kingdom published a report in April 2014 stating that health care spending in the United Kingdom amounted to £144.5 billion in 2012. This is a 1.9% increase from 2012. The ONS (2014) further mentioned that health care expenditure represented around a third of total government spending and has almost tripled since 1997.

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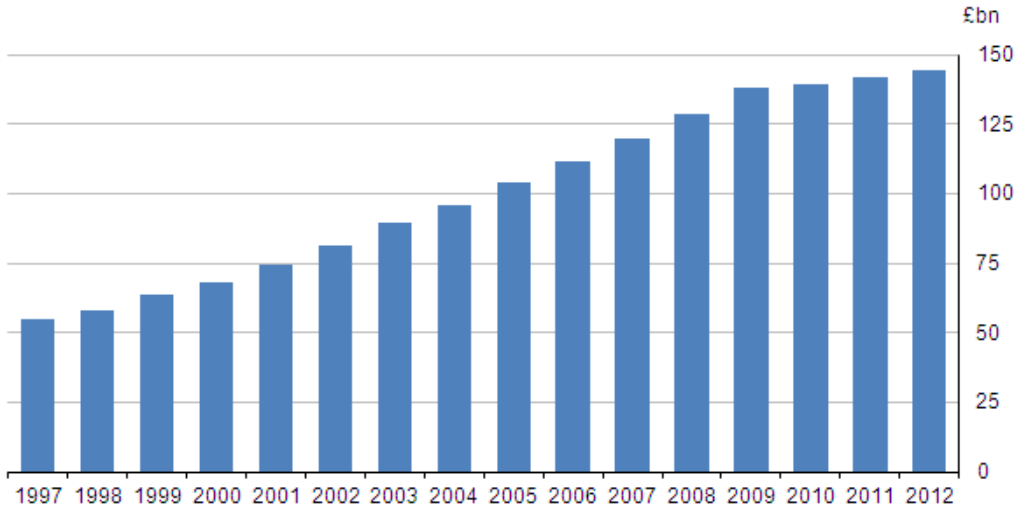

Figure 4.2: United Kingdom health care spending
Source: United Kingdom Office of National Statistics (2014)

According to the World Bank (2014a; 2014b), the United Kingdom spent 9.4% of its US $2 521 billion GDP on health care in 2012, which is on par with the average OECD median of 9.3%. This is comparable to a GDP per capita expenditure of US $3 647 in 2012.

The ONS (2014) stated that 84% of all health care expenditure in the United Kingdom came from public funds as opposed to 16% spent by individuals on private health care.

The United Kingdom had a 6.8% unemployment rate in the first half of 2014 which is below the OECD average of 7.3% This fact aids government in funding health care as the United Kingdom has a large base of tax contributors (OECD Stat Extract, 2014).

4.4.3 Who is covered?

The NHS official website states that the NHS remains free of charge for any individual who is a United Kingdom resident. At present, this amounts to over 63.2 million people. The National Health System in the United Kingdom serves over 1 million patients in every 36-hour cycle with services including anything from antenatal screening or routine treatments for long-term conditions, to transplants, emergency treatments and palliative care (NHS Choices, 2013).

4.4.4 Advantages and disadvantages of the health system in the United Kingdom

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Boyle (2011) mentions in his in-depth health system review of the United Kingdom that despite all the criticism and proposed changes, the NHS still provides substantial advantages to the citizens of the United Kingdom. These advantages include:

- Health care for most United Kingdom residents are free of charge.
- A comprehensive package of benefits are being offered to citizens.
- Constant observation ensures the NHS system runs as smoothly and efficiently as possible.
- The long history and experience of the NHS have put a robust health care system in place that has stood the test of time.

Light (2003) describes the disadvantages of the United Kingdom health system as:

- Many hospitals are outdated and run-down.
- Chronic shortages of specialists are experienced in every field.
- The NHS is known for their long waiting lists to receive medical care.
- Continuous underfunding and an undersupply of personnel and equipment.

4.4.5 Lessons to be learnt from the United Kingdom

Light (2003) summarised the most important lessons that other nations can learn from the United Kingdom's long NHS history in the American Journal of Public Health as follows:

1. Health care should be free at the point of service.
2. A large component of health care funding should be derived from income taxes.
3. A strong primary health care system should be established.
4. Medical staff should be adequately remunerated for working in rural areas.
5. Reduce inequalities in historic funding that used to favour the wealthy.
6. Pay all doctors on the same salary scale.
7. Control the cost of prescription drugs whilst promoting research into breakthrough drugs.

4.5 CONCLUSION

Table 4.3 below represents a comparative analysis which provides an overview of the three first world countries explored in this chapter. It is evident that rising costs are the single greatest challenge facing first world countries. The three countries discussed, namely France, the United Kingdom and the United States of America, are all attempting to manage costs whilst maintaining efficiency and access.

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One of the most important lessons learnt from these first world countries is that a health care reform takes time and is not achieved overnight. France, specifically, has been developing its national health insurance scheme for over seventy years.

The most significant finding from analysing the United States system is that health care costs must be managed to prevent uncontrolled commercialism which causes costs to skyrocket. The United States is struggling with private sector domination of health care provision, which has caused health care expenditure to soar out of control without achieving universal access for all its population. It can therefore be concluded that a co-ordinated financing system is imperative in achieving affordable health care for a country as a whole.

Whilst the United Kingdom was once at the forefront of national health with its bold approach admired by other nations, its single payer system is now outdated and almost unique. Growth in health care expenditure has far outpaced the rise in both GDP and total health care expenditure.

These findings will be applied to the South African context in Chapter 6, which will discuss how South Africa can learn from other nations when defining its own approach to national health.

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	France	United States	United Kingdom
Name Of Health System	Sécurité Sociale (Section 4.2.1)	Patient Protection and Affordable Care Act (Section 4.3.1)	National Health Service (NHS) (Section 4.4.1)
Population	66 Million (Section 4.2.1)	314 Million (Section 4.3.1)	63.2 Million (Section 4.4.3)
Total GDP	US $2 734 Billion (Section 4.2.2)	US $16 244 Billion (Section 4.3.2)	US $2 521 Billion (Section 4.4.2)
GDP Percentage Spent On Health Care	11.7% (Section 4.2.2)	17.9% (Section 4.3.2)	9.4% (Section 4.4.2)
Average per capita amount spent on health care	US $4 968 (Section 4.2.2)	US $8 680 (Section 4.3.2)	US $3 647 (Section 4.4.2)
Unemployment Rate	10.2% (Section 4.2.2)	6.3% (Section 4.3.1)	6.8% (Section 4.4.2)
Health Model Used	Bismarck	Combination	Beveridge
Most Important Lessons Learnt	• It is possible to achieve universal coverage without a single payer system. • Implementing a proper National Health Insurance system takes time. • Health care costs must be managed.	• Control health care spending. • Keep costs down as much as possible.	• Health care should be free of charge. • Large component of health care funding should be. derived from income taxes • Strong primary health care is important.

Table 4.2: Comparative analysis of first world countries

Source: Compiled by author

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CHAPTER 5

FUNDING HEALTH CARE IN THIRD WORLD COUNTRIES

5.1 INTRODUCTION

As discussed in the introduction of Chapter 4, South Africa is in the privileged position of being able to learn from the successes and failures of health care systems introduced by other countries around the world.

As South Africa is categorised as a third world developing country, it is of the utmost importance to investigate the implementation of health care funding models introduced by other comparable third world countries.

In order to understand the context in which health care financing will be discussed in this chapter, it is important to have a better understanding of what is meant by the term 'third world'. The term 'third world' is defined by One World Nations Online (n.d.) as:

> *"Third World are all the countries used to roughly describe the developing countries of Africa, Asia and Latin America."*

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It is further explained by the Merriam-Webster online dictionary as:

> *"A group of nations especially in Africa and Asia not aligned with either the Communist or the non-Communist blocs."*

Chapter 5 is devoted to the analysis of health care systems and their funding in selected third world countries. The countries that will be analysed, namely Brazil and Spain have been selected based on and because of certain similarities and characteristics that they share with South Africa. There are many lessons that can be learned from these two countries, which have comparable social and economic environments to South Africa, specifically with regard to challenges in health care provision and funding.

This chapter is premised on the understanding that South Africa is a nation with a lower general standard of living and an underdeveloped industrial base relative to other, more developed countries.

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5.2 BRAZIL

First and foremost, it is important to note that Brazil has been selected as part of this study because, along with South Africa, it forms part of the BRICS forum countries.

The BRIC concept was first developed by Jim O'Neill of Goldman Sachs in 2003 who identified countries that had fast-growing economies, with burgeoning middle classes and promising economic markets. These countries view themselves as an emerging centre of gravity in the global economy and initially only included Brazil, Russia, India and China. The BRIC forum was subsequently found in Yekaterinburg, Russia in 2009. This formalised O'Neill's concept as a platform from which to share views on how to respond to the challenges and opportunities presented by a globalising world (Qobo, 2010).

Qobo (2010) indicates that South Africa was admitted to this forum on 16 April 2010, which was subsequently renamed BRICS.

The BRICS countries represent 43% of the world's population resulting in the forum signifying a material portion of the world's population. The Fourth BRICS Summit held in Delhi in 2012 confirmed that most BRICS countries face a large number of similar public health challenges which include access to health services, increasing costs and the growing burden of communicable and non-communicable diseases (Council on Foreign Relations, 2012).

It is therefore relevant to investigate the Brazilian approach to health care in order for South Africa to benefit from Brazil's experience as the South African government faces similar challenges with the implementation of a national health insurance system.

5.2.1 Background to the Brazilian health care system

Jurberg (2008) states in the Bulletin of the World Health Organization that the Unified Health System was created in Brazil in 1988 with the promulgation of the new Federal Constitution. This was a dramatic commitment to the ideals of the 1978 Alma-Ata declaration of "health for all" and signalled the start of major health care reform in Brazil.

This reform acquired further traction in 1996 when Section 196 of the 1996 Brazilian Constitution established that health care was a fundamental right that all citizens are entitled to and a duty of the state to provide. The Constitution further stated that this

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service was to be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other dangers and was to provide equal access to health care for all citizens (Brazilian Constitution, 1996).

Jurberg (2008) further explains that this reform ushered in a health system based on decentralised universal access through increased focus on primary care, with municipalities providing comprehensive and free health care to each individual, financed by the state and federal government.

Brazil created the Family Health Programme (PSF) in 1994 as its main primary care strategy which provided a full range of quality health care to families either in their homes, at clinics or in hospitals (Jurberg, 2008).

According to Gragnolati, Lindelow and Couttolenc (2013), the Brazilian government had three ultimate goals in reforming its health system, which included:

- Improving the level and the distribution of health outcomes;
- Ensuring that health care funding was affordable and equitable; and
- Achieving high levels of responsiveness and satisfaction.

It is reported that Brazil is home to an estimated 190 million people, with a 5.4% unemployment rate and that currently 70% of the population is covered by the health care system, named the “Sistema Unico de Saude” (SUS). Jurberg mentions that about 30% of Brazilian citizens supplement these medical services provided by the government with additional private insurance (Jurberg, 2008 & OECD Stat Extract, 2014).

Jurberg (2008) points to three levels of government that form an integral part of the health system in Brazil, namely the federal, state and municipal levels. Binge (2010) explained that these three levels of government based the SUS on three principles, namely:

1. Universal and free access to health care for the entire population;
2. Free health care at all levels, from preventative care to complex hospital treatments; and
3. Funding and provision of health care shared between the three tiers of government mentioned above.

5.2.2 Funding of Brazilian health care

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Ernst & Young (2013) state that every citizen who earns wages, a salary or any form of income from a Brazilian source is subject to social security tax. This social security tax is withheld by the Brazilian employer.

The International Group Program (2013) stresses that these social security contributions include a range of benefits such as:

- Health care services;
- Retirement benefits (state pension);
- Death benefits;
- Disability benefits; and
- Family allowances.

According to the OECD Health Statistics (2014), health spending tends to rise with income, which translates into countries with a higher GDP per capita to normally spend more on health. It is therefore not surprising that Brazil ranks below the OECD average in terms of health expenditure per capita, with a per capita expenditure of US $1 109 in 2012, compared with the OECD average of US $3 484.

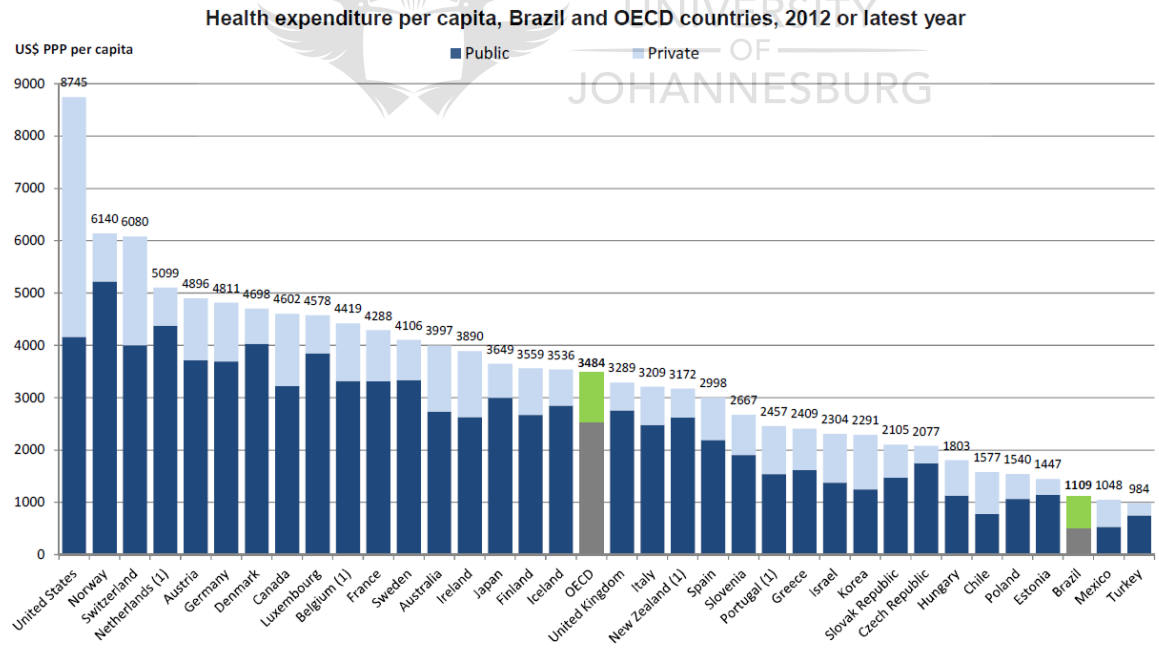

Figure 5.1: Health expenditure per capita in Brazil

Source: OECD Health Statistics (2014)

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Despite its per capita expenditure falling well below OECD averages, Brazil's 2012 total health expenditure amounted to 9.3% of GDP, which is on par with the OECD average (World Bank, 2013b).

It is important to note the role of private health financing in Brazil. When the SUS was established, reliance on the private health system was expected to decline steadily. This did not happen. Despite intentions to the contrary, private spending remained stable over the last twenty years and still accounted for 54% of total health expenditure in 2012 (Gragnolati *et al*., 2013).

5.2.3 Who is covered?

Gragnolati *et al*. (2013) researched the history of the SUS in Brazil and found that in 1981, 41% of the population reported that social security was their regular source of health care. It was further found that in 2008 only 58% of individuals reported being regular users of the SUS. These statistics show that initiatives aimed at drawing a larger share of the population into the public health system were not successful.

However, the Brazilian Ministry of Health (2010) further found other evidence suggesting that nearly all Brazilians made use of the SUS services at some point. A recent study indicated that the implementation of the system increased the number of Brazilian beneficiaries from 30 million to 190 million people, with nearly 80% of the population making use of the SUS exclusively.

The Brazilian Ministry of Health (2010) further explained that the Brazilian population falls into three groups with regards to access to health care services:

- Citizens who can afford private health care services;
- Registered workers / employees who have access to public health care secured by social security benefits; and
- Citizens with limited rights regarding health care.

5.2.4 Advantages and disadvantages of the Brazilian health care system

The reform in health care in Brazil has resulted in certain advantages and disadvantages. The main advantages as summarised by Binge (2010) are the following:

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- Focus of health care has been shifted from the individual to the family. This reduces pressure on traditional public health care providers such as hospitals and clinics.
- The Family Health Programme (PSF) is the central pillar of the primary health care strategy and has been expanding continuously. There are currently more than 5 100 PSF teams operating in the 5 564 municipalities in Brazil.
- The SUS reforms at least partially achieved the goals of universal and equitable access to health care. This has put Brazil in a better position than twenty years ago.

The disadvantages and challenges of the Brazilian health care system, however, cannot be ignored. One of the biggest criticisms of the Brazilian health care system is that despite the vast improvements made in covering individuals without previous access to health care, the quality of the care provided is still lacking.

Gragnolati *et al.* (2013) notes that the concept of 'coverage' does not adequately capture quality. In other words, not only do individuals need access to medical services, but those services must also be of suitable quality.

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Furthermore, Kay and Matijascic (2010) state that less than 30% of the Brazilian population has the finances to afford private health care, which means they are fully dependent on the Brazilian government for these services.

De Moraes and Carrara (2007) found that the main challenges Brazil faces in terms of its health care system are the following:

- Out-of-pocket payments are still an unavoidable reality. Twenty-five per cent of Brazil's health care expenditure consists of out-of-pocket payments for prescription medicine and dental care.
- Different social classes experience different types of access to health care, with lower-income households receiving unfair treatment with regards to access to care.
- The health system in Brazil is not administrated properly, which leads to inefficiencies.

5.2.5 Lessons to be learnt from the Brazilian health care system

A key component of the success of the Brazilian SUS over the past twenty years can be attributed to the implementation of their primary care strategy. The importance and

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advantage of starting health care reform at basic community level is a valuable lesson for South Africa.

It is clear that the Brazilian government made a concerted effort to reform its health care system. It is, however, important to note that an efficient health system is one that produces the greatest improvement for a given level of spending.

This is one of the most important lessons that South Africa can learn from the Brazilian example. South Africa needs to orchestrate greater improvement in its health system with the limited resources available.

5.3 SPAIN

A number of European countries are still struggling to recover from the 2007-2008 financial crisis that has swept the world and caused widespread hardship. Spain was one of the most severely affected countries, which is reflected in its staggering unemployment rate (Sinitsky, 2013).

South Africa is facing a similar predicament, with one of the highest unemployment rates in the world. Statistics South Africa (2014) state that the South African unemployment rate for the first quarter of 2014 was 25.5%. In comparison, OECD Stat Extract (2014) claims that the Spanish unemployment rate for the first half of 2014 was 24.6%.

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It is therefore evident that South Africa and Spain face similar challenges, particularly with regard to unemployment. It is for this reason that Spain has been selected as one of the third world countries in the overview of health care systems around the world.

Elteto (2011) notes that it is important to remember that Spain experienced a spectacular period of economic growth between the second half of the nineties until 2007. He further mentions that this “Golden Decade” led to a massive influx of foreigners, eager to take advantage of the financial boom. Elteto (2011) states that this high number of foreigners now forms part of the unemployment problem currently experienced by Spain.

5.3.1 Background to the Spanish health care system

In terms of Section 43 of the Spanish Constitution (1978):

- The right to health protection is recognised.

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- It is incumbent upon the public authorities to organise and safeguard public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all concerned in this respect.
- The public authorities shall promote health education, physical education and sports. Likewise, they shall encourage the proper use of leisure time.

According to Patxot, Renteria, Scandurra and Souto (2012), the Spanish national health system is the result of the transformation in 1984 to a Beveridgean model which guarantees free health care to all its citizens. The resulting national health care system is the "Sistema Nacional de Salud" (SNS).

The health reforms of the 1980s were mainly aimed at extending cover and access to health care services, thus completing the transition from a limited social security system to a universal national health service funded from taxes (García-Armesto, Abadía-Taira, Durán, Hernández-Quevedo & Bernal-Delgado, 2010).

Patxot *et al.* (2013) further explains that the country consists of seventeen highly decentralised independent communities (autonomous regions) and two independent cities in West Africa that each have the responsibility for health care in their own region.

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Peralta (2006) maintains that the Spanish health care system (SNS) is controlled by the state and autonomous community health departments. The state is responsible for the general organisation and co-ordination of health matters whereas the autonomous communities are responsible for planning, public health and health care provision in the respective regions.

In a report by the European Union (2013), it is explained that most health care services in Spain is generally free of charge and are provided exclusively through a network of health centres in the autonomous communities.

The European Union (2013) further states that most of the SNS providers are within the public sector and are managed through a contract programme.

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5.3.2 Funding of Spanish health care

Health care is one of the main instruments of the Spanish redistributive income tax system. All citizens contribute according to their wealth level and receive health care services according to their own needs. Almost all public health care is funded through general taxation. Taxation provides 94.07% of public resources whilst 5.93% is obtained through work injuries and profesional disease funds (García-Armesto *et al*. 2010).

In 2010, 72.1% of health spending was funded from public sources, with private insurance expenditure amounting to 5.5% and out-of-pocket spending contributing 22.4% of total expenditure (García-Armesto, *et al*. 2010).

Total health spending accounted for 9.3% of GDP in Spain in 2011, which is equal to the OECD average of 9.3%. It is important to note that the financial crisis led to an increase in the health spending to GDP ratio in Spain, as the GDP fell sharply since 2008 (OECD Health Data, 2013).

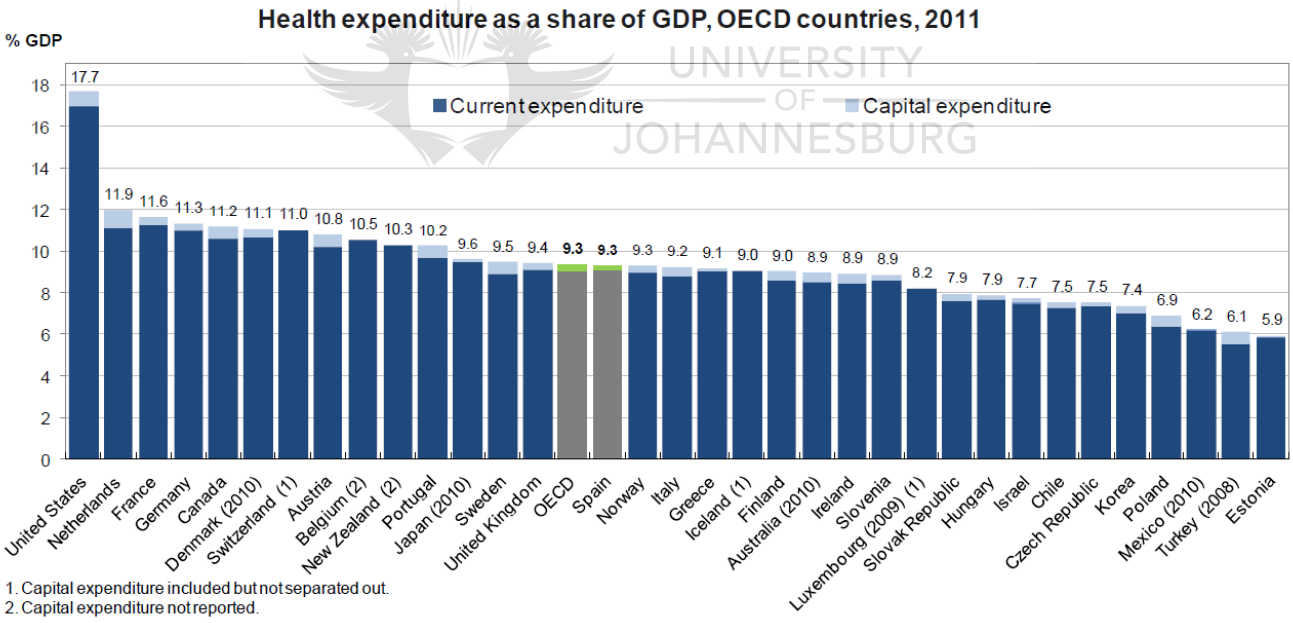

Figure 5.2: Spain health expenditure as percentage of GDP
Source: OECD Health Data (2013)

When analysing health care expenditure per capita, Spain is also on par with OECD averages. Spain's per capita health care expenditure amounted to US $3 072 in 2011, compared to the OECD average of US $3 339 (OECD Health Data, 2013).

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The Spanish Ministry of Health and Social Policy (2010) and Peralta (2006) agree that the health care services provided as part of the Spanish public health care include:

- Precautionary care;
- Diagnostic and therapeutic techniques;
- Rehabilitation;
- Care for children, youths and women;
- Care for the elderly;
- Health promotion and maintenance;
- Mental health care services;
- Care for the terminally ill;
- Specialist care;
- Emergency care;
- Pharmaceutical services;
- Orthopaedic and prosthetic benefits;
- Nutritional supplies; and
- Health care transportation (ambulance services).

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García-Armesto *et al*. (2010) mentions that private voluntary insurance has in the past played a relatively minor role in health care financing in Spain. This is, however, changing as an increasing number of people is turning to private health insurance to compensate for the increasingly struggling public health care services. Medical schemes cover 13% of the population, although there is considerable variation in different regions. It is further noted that citizens under the age of 65 need to contribute 40% out-of-pocket for any precribed medicine.

5.3.3 Who is covered?

With a population of 46 million people, Spain covers 505 955 km^2 and has the third largest surface area in Western Europe (García-Armesto *et al.* 2010).

As soon as individuals begin to work, they start making social security contributions. These contributions are calculated as a percentage of the contribution base, which is calculated by the government on a yearly basis (European Union, 2013).

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Angloinfo (2013) states that any person who is legally resident in Spain can qualify for benefits under the Spanish social security system if they fall into one of the following categories.

- Employed workers;
- Self-employed workers;
- Students;
- Workers affiliated with work co-operatives; or
- Civil servants and military personnel.

According to the European Union (2013), the following people are covered for health care services:

- Registered workers who are affiliated to a social protection scheme;
- Pensioners;
- Unemployed people who have exhausted their unemployment benefits;
- Family members of insured persons, as long as they reside in Spain;
- Some categories of irregular Spanish emigrants and some of their family members, whilst they are temporarily resident in Spain; and
- Legal residents whose income does not exceed the legally established limit.

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The Spanish Ministry of Health and Social Policy (2010) explains that health care provision in Spain is categorised as either Primary Care or Specialist Care. The characteristics of these two types of services are set out in the following table:

	Primary Care	**Specialist Care**
Feature	Accessibility	Technical Complexity
Activities	Health promotion and disease prevention as well as sufficient technical resources.	More complex and costly diagnostic and treatment resources.
Access	Spontaneous.	By referral from primary health care professionals.
Facilities	Health care centres and local clinics.	Specialist care centres and hospitals.

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Place of health care provision	In a health care centre.	Outpatient and inpatient.

Table 5.1: Primary Care and Specialist Care summary

Source: Spanish Ministry of Health and Social Policy (2010)

5.3.4 Advantages and disadvantages of the Spanish health care system (SNS)

The advantages of the Spanish health care system as described by García-Armesto *et al.* (2010) can be summarised as follows:

- Health care is generally accessible to the Spanish population.
- The Spanish system has resulted in good health statistics, for example, excellent life expectancy at birth.
- Pensioners are particularly well-looked after by the system.

The biggest disadvantages of the Spanish system are listed by Patxot *et al.* (2012) as:

- The recent worldwide economic crisis has led to reduced spending on health care in Spain.
- Certain challenges exist in access to health care between the different income levels of citizens in the various regions.
- An influx of foreigners over the last two decades has strained the Spanish government, which now needs to provide medical care to both the local and the foreign population.

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5.3.5 Lessons to be learnt from the Spanish health care system

Matthews (2010) lists the most important factors which have contributed to the success of the Spanish health care system as:

- Implementing a strong primary care system as an entry level health care mechanism.
- Ensuring that health care is accessible to the entire population.
- Organising public forums in order for the population to voice any constraints.
- Orchestrating a system-wide approach involving the various actors within the health care system.
- Making use of electronic health records, accessible from any health care centre.

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- Managing foreigners and their access to care to prevent a decline in services offered to the local population.

5.4 CONCLUSION

Table 5.2 below represents a comparative analysis which provides an overview of the two third world countries explored in this chapter, as well as South Africa investigated in Chapter 2. It is evident that providing universal and quality health care to an entire population of a developing country is not an easy task.

Countries like Brazil and Spain, which have a lower general standard of living, face enormous challenges in supplying medical care to their citizens.

The social and economic situations in these third world countries bear a significant impact on health care provision.

Brazil is densely populated, with nearly 190 million people, compared to the 51.9 million people living in South Africa. The Brazilian government has approached this massive task by emphasising primary care through a Family Health Programme (PSF). This has proven to be a very successful intervention and, as described above, health care statistics have improved significantly.

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Spain is comparable to South Africa because of the similarities in unemployment levels. The high unemployment rate in Spain has proven troublesome as a large portion of the population is unable to contribute to the funding of health care, yet still requires medical services. South Africa faces a similar situation and will need to give careful consideration of this issue when introducing the National Health Insurance programme.

These stumbling blocks facing third world countries will be discussed and applied to a South African context in Chapter 6, which outlines recommendations for the proposed national health system in South Africa.

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	South Africa	Brazil	Spain
Name Of Health System	National Health Insurance – Not yet in place.	Sistema Unico de Saude (SUS) (Section 5.2.1)	Sistema Nacional de Salud (SNS) (Section 5.3.1)
Population	51.9 Million (Section 5.4)	190 Million (Section 5.2.1)	46 Million (Section 5.3.3)
Total GDP	US $350 Billion (Section 2.2.2)	US $2 248 Billion	US $1 358 Billion
GDP Percentage Spent On Health Care	8.3% (Section 2.2.2)	9.3% (Section 5.2.2)	9.3% (Section 5.3.2)
Average per capita amount spent on health care	US $943 (Section 2.2.2)	US $1 109 (Section 5.2.2)	US $3 072 (Section 5.3.2)
Unemployment Rate	25.5% (Section 2.2.1)	5.4% (Section 5.2.1)	24.6% (Section 5.3)
Health Model Used	To be finalised	Beveridge	Beveridge & Out-Of-Pocket combination
Most Important Lessons Learnt	N/A	• Importance of a primary care strategy. • Use the existing resources efficiently.	• Ensure that health care is accessible to the entire population. • Importance of a primary care approach. • Manage foreigners and their access to care.

Table 5.2: Comparative analysis of third world countries, including South Africa.

Source: Compiled by author

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CHAPTER 6

CONCLUSION

6.1 INTRODUCTION

With reference to the problem statement outlined in section 1.3 and the research objectives set out in section 1.4, this chapter will summarise and draw conclusions from the significant findings of this study.

Certain recommendations will be made and areas for future research will be identified.

6.2 DEDUCTIONS

After taking into consideration the literature reviewed as well as the analysis of different health care systems around the world, it is vital to reflect on the lessons learnt from the selected health care systems of France, the United Kingdom, the United States of America, Brazil and Spain.

The following important points can be deduced from the five countries investigated in Chapters 4 and 5.

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6.2.1 Deductions based on international lessons:

- South Africa's health system needs to be re-engineered in order to achieve broader coverage and a more comprehensive service offering.
- South Africa needs to obtain a detailed understanding of the successes and failures of other countries which have attempted similar reforms in order to formulate the best possible approach.
- This detailed understanding should be based on lessons learnt from countries with similar socio-economic profiles to that of South Africa.
- It took other countries decades to establish universal health care systems on the scale that South Africa is contemplating. The South African government needs to be patient and realise that this is a long-term strategy.
- The implementation of a National Health Insurance scheme will require significant administrative infrastructure. Managing the proposed NHI scheme will be one of the most important aspects in ensuring the success of such a

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reform. Emphasis should thus be placed on administrative infrastructure requirements.

- Raising additional tax revenue for the health care system will have major repercussions on the economy. The funding approach should therefore be very carefully considered in order to be mindful of the impact it will have on the economy.
- While the private health care system in South Africa is very costly, it is an effective, high quality, self-sustaining system funded by the voluntary contributions of the public. As noted in other first world countries, the private health care system needs to be seen as part of the solution in South Africa's health care transformation.
- Universal coverage is more easily achieved when a central regulatory body governs the provision of health care services through an organised fund.
- Health care service provider fees need to be standardised in order to prevent uncontrolled commercialism.

6.2.2 Deductions based on South Africa's current health care scenario:

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- The absence of a formal policy document regarding the planned implementation of the National Health Insurance programme leads to numerous barriers in the planning and evaluation process.
- The analysis of the government's initial Green Paper indicates that this reform process is very ambitious and potentially risky as it will require major changes to the current funding model.
- It is of vital importance that proposals are based on hard evidence of the health care scenario in South Africa and not on ideological assertions motivated by the government's political ambitions.
- In order to facilitate a successful transformation to a National Health Insurance programme, the possible health care reform must be rooted in South Africa's economic realities.
- The ever-worsening problems of South Africa's public hospital system need to be addressed as soon as possible. This forms the backbone of the national health care system and fixing it must be one of the highest priorities.

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- South Africa is struggling with the unfortunate reality of one of the world's highest unemployment rates. This will result in a relatively small number of employed tax payers carrying the cost of the envisaged health care benefits for the entire population. One of the major dilemmas related to the proposed South African NHI is the high level of unemployed individuals who will have to be subsidised.
- The harsh reality is that at South Africa's stage of economic development, a National Health Insurance scheme will only be able to provide a very limited package of benefits beyond what is already provided through the public health care system.

6.3 TAXATION PERSPECTIVE

- In Chapter 1, the question was raised of whether the introduction of a National Health Insurance scheme would be fair to all South African citizens. The additional tax burden that will be created to fund the expansion and restructuring of health care in South Africa will, without a doubt, add to the financial pressures that individuals and consumers are already experiencing.
- The three funding models that are currently being investigated, namely an increase in VAT, payroll taxes or tax surcharges, will undeniably put further financial strain on South African citizens.
- An increase in the VAT rate would be the only financing model to include the entire South African population in the funding of NHI. As discussed in Chapter 2, VAT is an indirect form of taxation that affects all citizens as everybody pays VAT on goods purchased. One of the main advantages of using this funding model is that the infrastructure for VAT collections is already in place. Without having to incur any substantial additional costs, the South African Revenue Service will be able to collect the extra VAT through existing collection channels. The main criticism against this form of financing, however, is that it will have a significant negative impact on the poor population of South Africa.
- The introduction of a possible payroll tax to fund the proposed National Health Insurance scheme through a dedicated Pay-As-You-Earn (PAYE) payroll tax is also a viable solution. This would result in all employed South Africans contributing to an insurance fund responsible for financing the proposed health

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reform. The main objection to this form of financing, however, is the ratio of employed individuals contributing to such a fund versus the unemployed masses which would subsequently have to be subsidised.

- A possible tax surcharge, on the other hand, would result in income that has already been taxed being taxed at a higher rate to obtain the required funding. This would most probably lead to increased tax rates and would put further strain on the South African economy.
- In order to conclude this taxation perspective, it is clear that to implement a funding mechanism that is fair to all South Africans, the government will have to be very cautious when selecting a funding model. It is imperative that the government understands the sensitivity of the matter as well as its responsibility in constructing a funding approach that is economically viable.

6.4 RECOMMENDATIONS

After careful consideration the following recommendations should be taken into consideration when implementing a National Health Insurance system in South Africa.

- South Africa's main responsibility is to implement a health care system that is based on individuals having a right to health care, whilst secondly acknowledging the responsibility and obligation of society to look after the health of its people.
- The public health sector in South Africa will need a complete overhaul in order to make National Health Insurance a success.
- To ensure the successful implementation of National Health Insurance and to limit the impact its funding will have on taxpayers, collaboration will need to include all stakeholders.
- The South African government should aim to provide universal access for all South Africans whilst offering a decent package of health care benefits.
- South Africa should use a combination of public and private health care systems. Private health care should be seen as part of the solution and not as a threat to the reform process in South Africa. The vast number of professionals in the private health care sector, as well as their skills, should be utilised in order to offer the best possible solution for South African citizens.

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- As was seen in many of the countries compared, the regulation of prices in the health care market has played an enormous role in curbing health care costs. This will also keep uncontrolled commercialism in check and prevent role players from making exorbitant profits at public expense.
- Focus should be placed heavily on primary care. Many of the successes in comparable countries like Brazil are based on an intense primary care strategy. This will relieve pressure on hospitals and professional health care centres, as families and households will receive better care at community level.
- Drastic improvements should be made to medical services in rural areas in order to provide equal access to health care for all citizens.
- Pensioners should be treated with extra care. This could improve the life expectancy in South Africa.
- Health services should be readily available and waiting times at hospitals and clinics should be decreased.

As discussed in Chapter 3, most health care systems around the world are based on different, historical health care models. Some countries follow one specific model, for example, the system in the United Kingdom is based purely on a Beveridgean model whereas Germany and France follow a clear-cut Bismarck model. Other countries such as Spain, Brazil or the United States have chosen to adopt a combination approach and have implemented elements of different models.

It is evident that first world countries tend to implement health care systems funded through employment-based contributions. The main concern for South Africa is its high unemployment rate which will impede such a system. Third world countries lean towards a more government-funded approach where health care funding is obtained from a general pool of tax funds.

The author of this study is of the opinion that South Africa will have to follow a combined approach where funding needs to originate from both a payroll tax for the employed, as well as a government-funded component for the unemployed. This would ensure that funds are allocated to the NHI scheme through the existing tax channels without placing the entire funding burden on the employed citizens of South Africa.

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Another possible approach is the implementation of different levels of benefits for different category contributors. This would enable South Africa to still work towards universal coverage of basic health care needs while limiting certain procedures and expensive pharmaceutical treatments to contributors.

6.5 AREAS FOR FURTHER STUDY

The following areas have been identified for further possible research:

- The impact of a health payroll tax on employers.
- The impact of a possible VAT increase on both the individual and the private sector.
- The impact on society of contributions to both private and public health care funds.
- The effect of non-residents and foreigners on the South African health care system through an investigation of the health care benefits these individuals have access to in relation to the contributions they make to funding.

6.6 CONCLUSION

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After careful consideration of the deductions, the tax perspective and the recommendations of this study, it can be concluded that South Africa should first and foremost focus on spending the money that is currently budgeted for health care more efficiently. In order to ensure that South African taxpayers obtain the best possible medical care without serious increases in spending, which would have to eventually be recovered from taxpayers, corruption and wastage should be eliminated. It is clear that South Africa will not be able to successfully implement such a major health care reform if government cannot manage to curb the imminent collapse of the current health care system by rooting out all administrative malpractice and reckless, uncontrolled spending.

Although it is clear that a major health care reform in South Africa will have a serious impact on the country as a whole, it is imperative that some form of change be attempted without burdening the taxpayers to such an extent that it will cripple the economy and the financial wellbeing of the South African general public.

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In line with the Alma Ata Declaration of 1978, the South African government has a responsibility towards all citizens to improve the current health care system within the limitations of the resources available. The South African government should continue striving towards a comprehensive yet cost-effective solution to the health care predicament the country is facing.

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