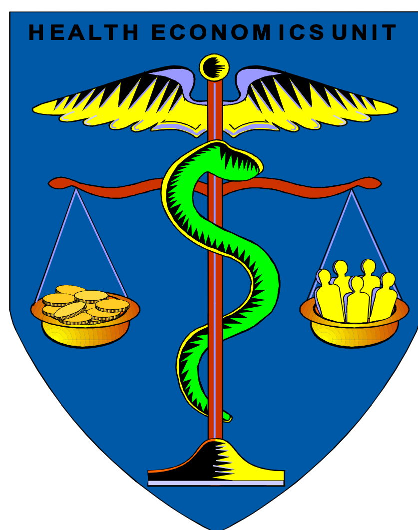
Revenue collection, fund pooling and purchasing: Key issues for NHI in South Africa



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Cutting the Gordian Knot

Overview

- Brief context
- Key principles
- Framework
- Key issues from international experience and implications for South Africa

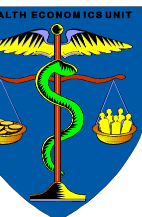
Trends in public-private mix (real)

Rand per capita

7,000
6,000
5,000
4,000
3,000
2,000
1,000
-

1998 1999 2000 2001 2002 2003 2004 2005

Public sector — Medical schemes



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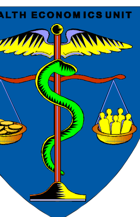
Balance of power in purchasing

Group	1996	2006
Independent	49.1%	16.2%
Netcare	20.2%	30.6%
Medi-Clinic	19.0%	25.3%
Afrox/Life	11.7%	27.9%

Van den Heever 2007

PLUS: **Vertical integration**

Compared with over 120 schemes & number of options in each

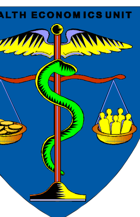


Public-private mix in funds (2005)

- 14.8% of population covered by medical schemes: **R9,500** per beneficiary (scheme and out-of-pocket)

- 21% of the population use private sector on an out-of-pocket basis for PHC and public sector for hospital care: **R1,500** per person

- 64.2% entirely dependent on public sector: **R1,300** per person (government funding)



The American nightmare?

	Tax	OOP	Medical schemes
Funds			
Beneficiaries	? 66%, very low income & unemployed	? 20%, low income formal & informal sector	14%, high & middle income, formal sector

Massive fragmentation of pools

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Context: Bottom line

- Sustained, large increases in medical schemes' expenditure and contributions; but stagnant membership

- Under-resourcing (financial & human resources) of public sector relative to population served

- Rapidly growing public-private mix disparity

Key principles

- Universal cover:
  - Health system that provides *all* with *adequate* health care at an *affordable* cost (WHO) ***PLUS***
- Promote cross-subsidies in *overall* health system:
  - Wealthy to poor (pay according to ability to pay)
  - Healthy to ill (benefit according to need for care)

Key objectives of NHI

- Seen in SA debates as a mechanism for addressing:

  - Challenges in medical schemes (voluntary, private insurance) environment

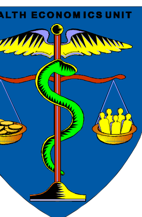
  - Public-private mix disparities (through promoting social solidarity)

Framework

- Focus on key ***functions*** of health care financing
  - Revenue collection (sources of funds, structure of contributions and how collected)
  - Pooling (deals with unpredictability of illness & inability of individuals to mobilise resources → need to pool risk across individuals and over time)
  - Purchasing (transfer of pooled resources to health service providers so appropriate & efficient services available to population)
  - Provision (health care delivery)

Revenue collection

- General tax revenue undoubtedly the most progressive financing source
- <11% of government budget allocated to health sector (below Abuja target of 15%)
- Calls for greater public spending on health sector not at expense of other social services
- Mandatory insurance contributions frequently a flat percentage of salary, limiting progressivity



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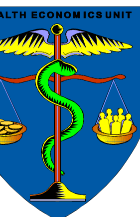
Revenue collection continued

- Private voluntary insurance 'progressive' in low- and middle-income countries: only the rich pay, ***but*** only the rich benefit
- Out-of-pocket payments are most regressive form of financing:
  - International consensus to prioritise pre-payment
  - Major burden of OOPP on medical scheme members
- Collecting organisation critical – degree of trust in government *and* in private organisations potentially a challenge

Fund pooling

- "Systems in which the degree of risk pooling is greater, achieve more" (WHO)
  - Maximise 'integration' across financing mechanisms:
    - No or limited pooling in out-of-pocket payments and medical savings accounts
    - Risk-equalisation mechanisms critical ***if*** a number of fragmented pools
    - Trend to integrate mandatory contributions for health with general tax funds



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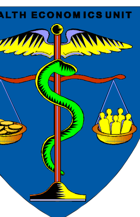
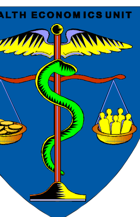
Purchasing

- Need for active purchasing – needed services; access secured; value for money
- Combination of regulation and 'holding the purse-strings' / balance of power with purchaser (for both public and private providers)
- Benefit package – wide range internationally, but focus on 'negative list' in universal systems
- Provider payment – fee-for-service least desirable



NHI in Ghana

- Goal of universal coverage from outset
- District wide mutual insurance schemes, covering formal & informal sectors:
  - Payroll deduction for formal sector workers
  - Others contribute directly to scheme
  - Tax and donor funds subsidise contributions of the poor
  - Risk-equalisation between district schemes



NHI in Ghana

2.5% sales tax

2.5% SSNIT

MoH funds

NHI fund

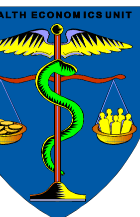
(% of MHIS funds from NHIF)

Metro-politan MHIS

Large town MHIS

Poor rural MHIS

Informal sector members' contributions



Key issues

- Range of different paths we can take
- Avoid trying to 'import' models – context specific
- Non-negotiables:
  - Commitment from outset to achieving universal system in shortest possible time
  - Implies an integrated pool for cross-subsidies
  - Carefully managed ***process*** in terms of revenue collection, pooling, purchasing and provision with improved ***governance*** cross-cutting